

Please try to answer each question, even if you do not think it is related to you at this time. There are no right or wrong answers. Please answer exactly as you think or feel. Thank-you.

1. Please check (✓) the ONE best answer for your abilities OVER THE PAST WEEK:

OVER THE PAST WEEK

Were you able to:

Without **ANY** With **SOME** With **MUCH** **UNABLE**
Difficulty Difficulty Difficulty To Do

DRESSING & GROOMING

- | | | | | |
|-----------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Dress yourself, including tying shoelaces and doing buttons? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Shampoo your hair? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

ARISING

- | | | | | |
|------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| c. Stand up from an armless chair? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Get in and out of bed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

EATING

- | | | | | |
|--------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| e. Cut your meat? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Lift a full cup or glass to your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Open a new milk carton? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

WALKING

- | | | | | |
|----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| h. Walk outdoors on flat ground? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Climb up five steps? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please check any **AIDS OR DEVICES** that you usually use for any of these activities:

- | | |
|-------------------------------------|--------------------------------------------------------------------------------------|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Devices used for dressing (button hook, zipper puller, etc) |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Built-up or special utensils |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Special or built up chair |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Other (specify): _____ |

Please check any categories for which you need **HELP FROM ANOTHER PERSON**

- | | |
|------------------------------------------------|----------------------------------|
| <input type="checkbox"/> Dressing and Grooming | <input type="checkbox"/> Eating |
| <input type="checkbox"/> Arising | <input type="checkbox"/> Walking |

HYGIENE

- | | | | | |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| j. Wash and dry your entire body? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Take a tub bath? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Get on and off the toilet? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

REACH

- | | | | | |
|------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| m. Reach and get a 5-lb object (such as a bag of sugar) from just above your head? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Bend down and pick up clothing from the floor? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

GRIP

- | | | | | |
|-------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| p. Open car doors? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Open jars which have been previously opened? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Turn faucets on and off? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

ACTIVITIES

- | | | | | |
|--------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| s. Run errands and shop? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| t. Get in and out of a car? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| u. Do chores such as vacuuming, yard work? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Please
Turn
Over** ↩

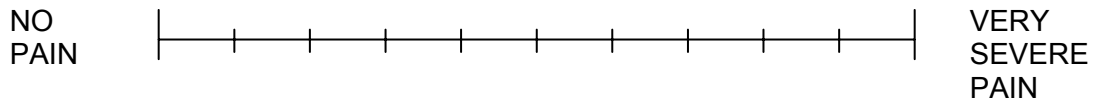
Please check any **AIDS OR DEVICES** that you usually use for any of these activities:

- Raised toilet seat
- Long-handled appliances for reach
- Bathtub seat
- Long-handled appliances in bathroom
- Jar opener
- Bathtub bar
- Other (Specify): _____

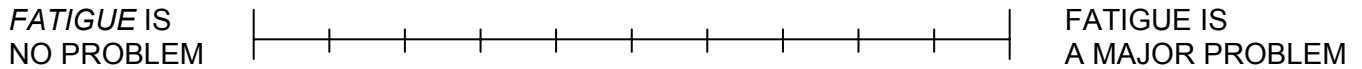
Please check any categories for which you **NEED HELP FROM ANOTHER PERSON**

- Hygiene
- Gripping and opening things
- Reach
- Errands and chores

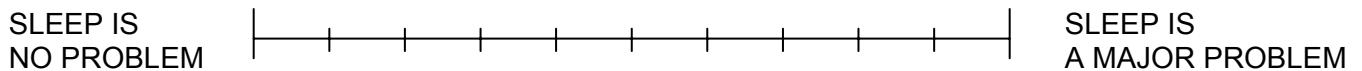
2. How much **PAIN** have you had because of your illness in the **PAST WEEK**? Please indicate on the scale below how severe your pain has been:



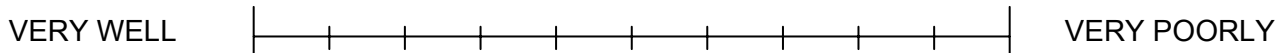
3. How much of a problem has **UNUSUAL** fatigue or tiredness been for you **OVER THE PAST WEEK**? Place a mark on the line below



4. How much of a problem has sleeping been for you **OVER THE PAST WEEK**? Place a mark on the line below



5. Considering all the ways in which illness and health conditions may affect you at this time, please make a mark on the line below to show how you are doing:



6. When you get up in the morning do you feel stiff? YES NO

If you answer NO please go to item number 7.

If you answer YES, please write the number of minutes: _____, OR number of hours: _____ until you are as limber as you will be for the day?

7. How do you feel today compared to **ONE MONTH AGO**? Please check only one:

- MUCH BETTER(1)
- BETTER(2)
- THE SAME(3)
- WORSE(4)
- MUCH WORSE(5)

For office use only

HAQ	PN	FT	SL	GL	AM	CH	1=0.125	7=0.875	13=1.625	19=2.375
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2=0.25	8=1.0	14=1.75	20=2.5
							3=0.375	9=1.125	15=1.875	21=2.625
							4=0.5	10=1.25	16=2.0	22=2.75
							5=0.625	11=1.375	17=2.125	23=2.875
							6=0.75	12=1.5	18=2.25	24=3.0
0-0.5 Mild → 0.5-1.0 Mild-Mod → 1.0-1.5 Mod → 1.5-2.0 Mod-Sev → 2.0-3.0 Sev										