**Patient Name:****Date:**

**Over the last week, were you able to: Without With Some With Great Unable**

 **Difficulty Difficulty Difficulty to Do**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Dress yourself, including tying shoes and doing buttons? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Get in and out of bed? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Lift a full cup or glass to your mouth? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Walk outdoors on flat ground? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Wash and dry your entire body? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Bend down to pick up clothing from the floor? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Turn regular faucets on and off? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Get in and out of a car, bus, train or airplane? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Walk two miles or three kilometers if you wish? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Participate in recreational activities and sports as you would? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Get a good night sleep? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Deal with feelings of anxiety or being nervous? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Deal with feelings of depression or feeling blue? |  [ ]  |  [ ]  |  [ ]  |  [ ]  |

**Pain Scale (No Pain = 0, Pain as bad as it could be = 10) Please bubble in your level of pain**

No Pain Severe Pain

0 [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10 [ ]

**How much of a problem has UNUSUAL fatigue or tiredness been for you over the past week?**

No Fatigue Severe Fatigue

0 [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10 [ ]

**Considering all the ways in which health conditions affect you at this time, indicate how you are doing.**

Very Well Very Poorly

0 [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10 [ ]

**Current Joint pain None Mild Moderate Severe**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Left Finger |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Left Wrist |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Left Elbow |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Left Shoulder |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Left Hip |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Left Knee |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Left Ankle |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Left Toe |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Neck |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Right Finger |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Right Wrist |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Right Elbow |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Right Shoulder |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Right Hip |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Right Knee |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Right Ankle |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Right Toe |  [ ]  |  [ ]  |  [ ]  |  [ ]  |
| Back |  [ ]  |  [ ]  |  [ ]  |  [ ]  |