HEALTH ASSESSMENT QUESTIONNAIRE

In this section we are interested in learning how your illness affects your ability to function in daily life. Please feel free to add any comments on the back of this page.

Please check the response which best describes your usual abilities OVER THE PAST WEEK:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Without ANY Difficulty</th>
<th>With SOME Difficulty</th>
<th>With MUCH Difficulty</th>
<th>UNABLE To Do</th>
</tr>
</thead>
</table>

**DRESSING & GROOMING**

Are you able to:
- Dress yourself, including tying shoelaces and doing buttons?
- Shampoo your hair?

**ARISING**

Are you able to:
- Stand up from a straight chair?
- Get in and out of bed?

**EATING**

Are you able to:
- Cut your meat?
- Lift a full cup or glass to your mouth?
- Open a new milk carton?

**WALKING**

Are you able to:
- Walk outdoors on flat ground?
- Climb up five steps?

Please check any AIDS OR DEVICES that you usually use for any of these activities:
- Cane
- Devices used for dressing (button hook, zipper pull, long-handled shoe horn, etc.)
- Walker
- Built up or special utensils
- Crutches
- Special or built up chair
- Wheelchair
- Other (Specify: ________________________)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:
- Dressing and Grooming
- Eating
- Arising
- Walking
Please check the response which best describes your usual abilities OVER THE PAST WEEK:

<table>
<thead>
<tr>
<th></th>
<th>Without ANY Difficulty</th>
<th>With SOME Difficulty</th>
<th>With MUCH Difficulty</th>
<th>UNABLE To Do</th>
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</thead>
<tbody>
<tr>
<td><strong>HYGIENE</strong></td>
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<tr>
<td>Are you able to:</td>
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<tr>
<td>- Wash and dry your body?</td>
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<td></td>
<td>HYGNNEW_____</td>
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<tr>
<td>- Take a tub bath?</td>
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<tr>
<td>- Get on and off the toilet?</td>
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<tr>
<td>REACH</td>
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<tr>
<td>Are you able to:</td>
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<tr>
<td>- Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?</td>
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<td>REACHNEW_____</td>
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<tr>
<td>- Bend down to pick up clothing from the floor?</td>
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<tr>
<td>GRIP</td>
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<tr>
<td>Are you able to:</td>
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<tr>
<td>- Open car doors?</td>
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<td>GRIPNEW_____</td>
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<tr>
<td>- Open jars which have been previously opened?</td>
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<tr>
<td>- Turn faucets on and off?</td>
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<tr>
<td>ACTIVITIES</td>
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<tr>
<td>Are you able to:</td>
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<tr>
<td>- Run errands and shop?</td>
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<td>ACTIVNEW_____</td>
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<td>- Get in and out of a car?</td>
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<td>- Do chores such as vacuuming or yardwork?</td>
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<tr>
<td>Please check any AIDS OR DEVICES that you usually use for any of these activities:</td>
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<tr>
<td>_____ Raised toilet seat</td>
<td>_____ Bathtub bar</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>_____ Bathtub seat</td>
<td>_____ Long-handed appliances for reach</td>
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<tr>
<td>_____ Jar opener (for jars previously opened)</td>
<td>_____ Long-handed appliances in bathroom</td>
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<tr>
<td>_____ Other (Specify: ______________________)</td>
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<tr>
<td>Please check any categories for which you usually need HELP FROM ANOTHER PERSON:</td>
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<tr>
<td>_____ Hygiene</td>
<td>_____ Gripping and opening things</td>
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<td></td>
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<tr>
<td>_____ Reach</td>
<td>_____ Errands and chores</td>
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</tbody>
</table>

We are also interested in learning whether or not you are affected by pain because of your illness.

How much pain have you had because of your illness IN THE PAST WEEK:

PLACE A VERTICAL (I) MARK ON THE LINE TO INDICATE THE SEVERITY OF THE PAIN.

NO PAIN 0 100 SEVERE PAIN PAINSCAL