Arthritis Questionnaire

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Patient Name: _____Age:____ Date of Birth: _____Sex: M__F__

Marital status_____Best Phone number to contact ( ) _____ - _____

Ethnicity: ( ) Caucasian ( ) Hispanic ( ) Native American ( ) African-American ( ) Other

To be completed by the patient:

1. How much pain have you had in the past week because of your arthritis?
Please mark an "X" on the following scale to indicate the severity of your pain:

No Pain Worst Imaginable Pain
_____
0 50 100

2. Considering all the ways your arthritis affects you, mark "X" on the scale for how well you are doing?

Very Well Very Poor
_____
1 50 100

3. What is kind of work you do comfortably? Check all that apply.

Sitting only _____
Sitting and walking _____
Physical work more than hour_____ Stading hours in a row _____ Cooking _____
Housecleaning _____ Exercise moderatley _____ no exercise at all _____

4. Are your disabiled or retired, if yes since when? _____

5. How many days of work l have you missed because of your arthritis this year?_____

6. Have you had to reduce your working hours because of your arthritis?
No _____ Yes _____ If so, by how many hours per week? _____

7. Has another member of your family had to stop working or reduce their hours because of your arthritis?
No _____ Yes _____
If so, How? _____

8. Have you had to change your duties at work because of your arthritis?
No _____ Yes _____ If so, How?
_____
_____

9. Have you had to hire help for work at home because of your arthritis?
No _____ Yes _____ If so, what kind, How many hours/week, and at what
_____
_____

Please check the one response which best describes your usual abilities (Q 10 through Q13)
Without ANY Difficulty = 1
With SOME Difficulty = 2
With MUCH Difficulty = 3
Not AT ALL = 4

10. DRESSING & GROOMING
Are you able toDress yourself, including tying shoe laces :
Close and open buttons:
Shampoo your hair:

11. ARISING are you able to do without holding any thing:
Stand up from an armless straight chair:
Get in and out of bed:
EATING are you able to:

12. Your are able to cut your meat or Vegetables?
Lift a full cup or glass to your mouth:
Open a new milk carton:

13. WALKING are you able to:
Walk outdoors on flat ground:
Climb up five (5) steps:

14. Please check any AIDS or DEVICES that you usually use for any of these activities.
Cane _____ Wheelchair _____ Walker _____ Special or built up chair _____ Devices used for Dressing (button, hook, zipper
pull, long-handled shoe horn, etc.) _____ Back support (home) _____ Back support (car) _____
Other specify:_____

15. Please check any categories for which you usually need HELP FROM ANOTHER PERSON:
Dressing & Grooming _____ Eating _____ Arising _____ Walking _____None _____

Please check the one response which best describes your usual abilities.(Q16 through Q18)
Without ANY Difficulty = 1
With SOME Difficulty = 2
With MUCH Difficulty = 3
Can not DO AT ALL = 4

16. OVER THE PAST WEEK .
ABLE to do HYGIENE :
ARE you able to Wash and dry your entire body:
TAKE a tub bath:
Get on and off the toilet:

17. REACH & MOBILTY
Are you able to reach and get down a 5 lb object (such as a bag of sugar) from just above your head:
Bend down to pick up clothing from the floor:

17. GRIP

Are you able to open car doors:
Open jars which have been previously opened:
Turn faucets on and off:

18. ACTIVITIES are you able to:

Run errands and shop:
Get in and out of a car:
Do chores such as vacuuming or yard work:

19. Please check any AIDS or DEVICES that you usually use for any of these activities.

Raised Toilet Seat ___Bathroom Bar ___Bathtub Seat ___Long-Handled Appliances for Reach_____ Jar Opener (for jars previously opened) ____Long-Handled Appliances in Bathroom _____
Other (Specify): _____

20. Please check any categories for which you usually need HELP FROM ANTOHER PERSON:

Hygiene _____ Gripping and opening things _____ Reach _____ Errands and Chores_____

21. We are interested in knowing how your illness affects the daily activities of your life. Please feel free to add comments on bottom.

_____
_____
_____
_____
_____

Patient Name:_____ Date: _____(DD/MM/YY) Time_____

Reviwed by :_____ Date: _____(DD/MM/YY) Time_____