ARTHRITIS & RHEUMATIC CARE CENTER

Multi-Dimensional Health Assessment Questionnaire

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. 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 at this time:

OVER THE LAST WEEK, were you able to :	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	Unable To Do
a. Dress yourself, including tying shoelaces and doing buttons?	0 ____	1 ____	2 ____	3 ____
b. Get in and out of bed?	0 ____	1 ____	2 ____	3 ____
c. Lift a full cup or glass to the mouth?	0 ____	1 ____	2 ____	3 ____
d. Walk outdoors on flat grounds?	0 ____	1 ____	2 ____	3 ____
e. Wash and dry your entire body?	0 ____	1 ____	2 ____	3 ____
f. Bend down to pick up clothing from floor?	0 ____	1 ____	2 ____	3 ____
g. Turn regular faucets on and off?	0 ____	1 ____	2 ____	3 ____
h. Get in and out of a car, bus, train or airplane?	0 ____	1 ____	2 ____	3 ____
i. Walk two miles or three kilometers, if you wish?	0 ____	1 ____	2 ____	3 ____
j. Participate in recreational activities and sports as you would like, if you wish?	0 ____	1 ____	2 ____	3 ____
k. Get a good night's sleep?	0 ____	1.1 ____	2.2 ____	3.3 ____
l. Deal with feeling of anxiety or being nervous?	0 ____	1.1 ____	2.2 ____	3.3 ____
m. Deal with feeling of depression or feeling blue?	0 ____	1.1 ____	2.2 ____	3.3 ____

2. How much pain have you had because of your condition OVER THE PAST WEEK?

Please indicate below how severe your pain has been:

NO PAIN ☐ 0 ☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 2.5 ☐ 3 ☐ 3.5 ☐ 4 ☐ 4.5 ☐ 5 ☐ 5.5 ☐ 6 ☐ 6.5 ☐ 7 ☐ 7.5 ☐ 8 ☐ 8.5 ☐ 9 ☐ 9.5 ☐ 10 PAIN AS BAD AS IT COULD BE

3. Please check (✓) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
a. LEFT FINGER	☐ 0	☐ 1	☐ 2	☐ 3	i. RIGHT FINGER	☐ 0	☐ 1	☐ 2	☐ 3
b. LEFT WRIST	☐ 0	☐ 1	☐ 2	☐ 3	j. RIGHT WRIST	☐ 0	☐ 1	☐ 2	☐ 3
c. LEFT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3	k RIGHT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3
d. LEFT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3	l. RIGHT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3
e. LEFT HIP	☐ 0	☐ 1	☐ 2	☐ 3	m. RIGHT HIP	☐ 0	☐ 1	☐ 2	☐ 3
f. LEFT KNEE	☐ 0	☐ 1	☐ 2	☐ 3	n. RIGHT KNEE	☐ 0	☐ 1	☐ 2	☐ 3
g. LEFT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3	o. RIGHT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3
h. LEFT TOES	☐ 0	☐ 1	☐ 2	☐ 3	p. RIGHT TOES	☐ 0	☐ 1	☐ 2	☐ 3
q. NECK	☐ 0	☐ 1	☐ 2	☐ 3	r. BACK	☐ 0	☐ 1	☐ 2	☐ 3

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL 0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 VERY POORLY

Your Name ____________________ Date of Birth ____________________ Today's Date ____________________

Thank you for completing this questionnaire to help keep track of your medical care.

FOR OFFICE USE ONLY: I have reviewed the questionnaire responses. Date: Signature:				
1. a-j FN (0-10)	1=0.3 16=5.3 2=0.7 17=5.7 3=1.0 18=6.0	4=1.3 19=6.3 5=1.7 20=6.7 6=2.0 21=7.0	7=2.3 22=7.3 10=3.3 25=8.3 8=2.7 23=7.7 11=3.7 26=8.7 9=3.0 24=8.0 12=4.0 27=9.0	13=4.3 28=9.3 14=4.7 29=9.7 15=5.0 30=10.0
2. PN (0-10)	4. PTGL (0-10):		RAPID 3 (0-30):	Cat: HS = >12 MS = 6.1-12 LS = 3.1-5 R = <3