Health Assessment Questionnaire

Name: _____ Date: _____

We are interested in learning how your illness affects your ability to function in daily life. Place an X in the box which best describes your abilities **OVER THE PAST 7 DAYS – Do not fill this form out more then 7 days before your appointment.**

Are you able to:	**Without Any Difficulty (0)**	**With Some Difficulty (1)**	**With Much Difficulty (2)**	**Unable To Do (3)**	
Stand up from a straight chair?	☐	☐	☐	☐	
Walk outdoors on flat ground?	☐	☐	☐	☐	____
Get on/off toilet?	☐	☐	☐	☐	
Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐	____
Open car doors?	☐	☐	☐	☐	
Do outside work (such as yard work)?	☐	☐	☐	☐	____
Wait in a line for 15 minutes?	☐	☐	☐	☐	
Lift heavy objects?	☐	☐	☐	☐	____
Move heavy objects?	☐	☐	☐	☐	
Go up two or more flights of stairs?	☐	☐	☐	☐	____

Pain: How much pain have you had because of your illness **IN THE PAST 7 DAYS**? Place an X below, to best describe the severity of your pain on a scale of 0 – 10.

	0			**2**				**4**				**6**				**8**				**10**	
NO PAIN	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	SEVERE PAIN

Fatigue: How much of a problem has fatigue or tiredness been **IN THE PAST 7 DAYS**? Place an X below, to best describe the severity of your fatigue on a scale of 0 – 10.

	0			**2**				**4**				**6**				**8**				**10**	
FATIGUE IS NO PROBLEM	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	FATIGUE IS A MAJOR PROBLEM

Sleep: How much of a problem has sleep (ie, resting at night) been for you **IN THE PAST 7 DAYS**? Place an X below, to best describe how much of a problem sleep has been for you on a scale of 0 – 10.

	0			**2**				**4**				**6**				**8**				**10**	
SLEEP IS NO PROBLEM	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	SLEEP IS A MAJOR PROBLEM

Stress: How much stress are you currently under?

	0			**2**				**4**				**6**				**8**				**10**	
NO STRESS	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	COMPLETELY STRESSED OUT

Overall: Considering ALL THE WAYS THAT YOUR ILLNESS AFFECTS YOU, RATE HOW YOU ARE DOING on the following scale. Place an X below, to best describe how you are doing on a scale of 0 – 10.

	0			**2**				**4**				**6**				**8**				**10**	
VERY WELL	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	☐	☐	☐	○	VERY POOR