Patient Activity Scale (PAS)

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 usual abilities OVER THE PAST WEEK: Without Any Unable With Some With Much To Do Difficulty Difficulty Difficulty Are you able to: Dress yourself, including shoelaces and buttons? Shampoo your hair? Stand up from a straight chair? Get in and out of bed? Cut your meat? Lift a full cup or glass to your mouth? Open a new milk carton? Walk outdoors on flat ground? Climb up five steps? Please place an X in the box beside any aids or devices that you usually use for any of the above activities: Built up or special utensils Cane Crutches Walker Wheelchair Special or built up chair Devices used for dressing (button hook, zipper pull, long handled shoe horn) Other (please specify) Place an X in the box beside any categories for which you usually need HELP FROM ANOTHER PERSON: Dressing and Grooming Arising Eating Walking Place an X in the box which best describes your usual abilities OVER THE PAST WEEK: Without Anv With Some With Much Unable Difficulty Difficulty Difficulty To Do Are you able to: Wash and dry your body? Take a tub bath? Get on and off the toilet? Reach and get down a 5 pound object (such as a bag of sugar) from just above your head? Bend down to pick up clothing from the floor? Open car doors? Open jars which have been previously opened? Turn faucets on and off? Run errands and shop? Get in and out of a car? Do chores such as vacuuming or yard work? Please place an X in the box beside any AIDS or DEVICES that you usually use for any of the above activities: Bathtub bar Raised toilet seat Jar opener for jars previously opened Long-handled appliances for reach Long-handled appliances in bathroom Other (please specify)

Please place an X in the box beside any categories for which you usually need HELP FROM ANOTHER PERSON:

Gripping and Opening Things

Hygiene

Reach



Errands and Chores



| 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 an X in the box that best describes the severity of your pain on a scale of 0-10. | | | |
| | 0 | 10 | |
| NO PAI | | | SEVERE PAIN |
| Considering ALL THE WAYS THAT YOUR ILLNESS AFFECTS YOU, RATE HOW YOU ARE DOING on the following scale. Place an X in the box below that best describes how you are doing on a scale of 0-10. | | | |
| VERY WELL | 0 | 10 □ | VERY POOR |