

This questionnaire includes information from you to provide a record of your health status today. Please try to answer each question, even if you do not think it is related to your situation. 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:

AT THIS MOMENT, are you able to:	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do
a. Dress yourself, including tying shoelaces and doing buttons?	_____ 1	_____ 2	_____ 3	_____ 4
b. Get in and out of bed?	_____ 1	_____ 2	_____ 3	_____ 4
c. Lift a full cup or glass to your mouth?	_____ 1	_____ 2	_____ 3	_____ 4
d. Walk outdoors on flat ground?	_____ 1	_____ 2	_____ 3	_____ 4
e. Wash and dry your entire body?	_____ 1	_____ 2	_____ 3	_____ 4
f. Bend down to pick up clothing from the floor?	_____ 1	_____ 2	_____ 3	_____ 4
g. Turn regular faucets on and off?	_____ 1	_____ 2	_____ 3	_____ 4
h. Get in and out of a car, bus, train or airplane?	_____ 1	_____ 2	_____ 3	_____ 4
i. Run errands and shop?	_____ 1	_____ 2	_____ 3	_____ 4
j. Climb up a flight of stairs?	_____ 1	_____ 2	_____ 3	_____ 4
k. Walk two miles?	_____ 1	_____ 2	_____ 3	_____ 4
l. Run or jog two miles?	_____ 1	_____ 2	_____ 3	_____ 4
m. Drive a car 5 miles from your home?	_____ 1	_____ 2	_____ 3	_____ 4
n. Participate in sports and games as you would like?	_____ 1	_____ 2	_____ 3	_____ 4
o. Get a good night's sleep?	_____ 1	_____ 2	_____ 3	_____ 4
p. Deal with the usual stresses of daily life?	_____ 1	_____ 2	_____ 3	_____ 4
q. Deal with feelings of anxiety or being nervous?	_____ 1	_____ 2	_____ 3	_____ 4
r. Deal with feelings of depression or feeling blue?	_____ 1	_____ 2	_____ 3	_____ 4

2. How much pain have you had because of your condition IN THE PAST WEEK? Place a mark on the line below to indicate how severe your pain has been:

NO PAIN PAIN AS BAD AS IT COULD BE

3. The statements below concern your personal beliefs. Please circle the number beside each statement that best describes how you feel about the statement. There are no right or wrong answers.

	STRONGLY DISAGREE	DISAGREE	DO NOT AGREE OR DISAGREE	AGREE	STRONGLY AGREE
a. My condition is controlling my life.	1	2	3	4	5
b. I would feel helpless if I couldn't rely on other people for help with my condition.	1	2	3	4	5
c. I am concerned that medicines cannot help me.	1	2	3	4	5
d. The side effects of medicines are often worse than the disease.	1	2	3	4	5
e. I often do not take my medicines as directed.	1	2	3	4	5
f. No matter what I do, or how hard I try, I just can't seem to get relief from my symptoms.	1	2	3	4	5
g. I am <u>not</u> coping effectively with my condition.	1	2	3	4	5
h. It seems as though fate and other factors beyond my control affect my condition.	1	2	3	4	5

4. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK? Place a mark on the line below:

FATIGUE IS NO PROBLEM FATIGUE IS A MAJOR PROBLEM

Figure 1. Multidimensional Health Assessment Questionnaire, which includes the modified Health Assessment Questionnaire, advanced activities of daily living, and psychological items in the format of the Health Assessment Questionnaire, as well as visual analog scales for pain and fatigue, and the Rheumatology Attitudes Index to assess helplessness between the pain and fatigue scales.