

## Cervical Follow-up Form

Spine problems have a big impact on your life. We are interested in knowing about the effects of your symptoms on your physical and emotional health.

Medical Record Number:

\_\_\_\_\_

Date:

\_\_\_\_\_

(MM/DD/YYYY)

E-mail address:

\_\_\_\_\_

When you provide your e-mail address you will be able to complete future surveys in the comfort of your own home rather than in the clinic.

Please select the one item that most accurately reflects your satisfaction with surgery.

- <sub>1</sub> The treatment met my expectations
- <sub>2</sub> I did not improve as much as I had hoped but would undergo the same treatment for the same outcome
- <sub>3</sub> I did not improve as much as I had hoped and I would not undergo the same treatment for the same outcome
- <sub>4</sub> I am the same or worse than before surgery

Are you currently working?

- <sub>0</sub> No
- <sub>1</sub> Yes

If you are not currently working, please provide reason.

- <sub>1</sub> Retired (not due to illness)
- <sub>2</sub> Disabled and/or retired due to illness
- <sub>3</sub> Looking for work
- <sub>4</sub> Elected not to work (e.g. Homemaker)
- <sub>5</sub> Attending school

Since your surgery or last visit, have you received any physical therapy?

- <sub>0</sub> No
- <sub>1</sub> Yes

If yes, how many clinic sessions have you had?

\_\_\_\_\_

(clinic sessions)

If yes, how many home sessions have you had?

\_\_\_\_\_

(home sessions)

Since your surgery or last visit, have you been admitted to the hospital?

- <sub>0</sub> No
- <sub>1</sub> Yes

If yes, please describe your most recent hospitalization:

\_\_\_\_\_

Since your surgery or last visit, have you had additional spine surgery?

- <sub>0</sub> No
- <sub>1</sub> Yes

If yes, please describe your recent spine surgery:

\_\_\_\_\_

Are you currently taking narcotic medications?

- \_0 No
- \_1 Yes

**Pain Intensity**

Please rate your NECK pain by selecting the one number that best describes your pain at its WORST in the past week.

- \_ (No Pain)   \_1   \_2   \_3   \_4   \_5   \_6   \_7   \_8   \_9   \_10 (Worst Pain)

Please rate your NECK pain by selecting the one number that best describes your pain at its AVERAGE in the past week.

- \_ (No Pain)   \_1   \_2   \_3   \_4   \_5   \_6   \_7   \_8   \_9   \_10 (Worst Pain)

Please rate your ARM/SHOULDER pain by selecting the one number that best describes your pain at its WORST in the past week.

- \_ (No Pain)   \_1   \_2   \_3   \_4   \_5   \_6   \_7   \_8   \_9   \_10 (Worst Pain)

Please rate your ARM/SHOULDER pain by selecting the one number that best describes your pain at its AVERAGE in the past week.

- \_ (No Pain)   \_1   \_2   \_3   \_4   \_5   \_6   \_7   \_8   \_9   \_10 (Worst Pain)

Select the one number that describes how during the past week pain has interfered with your activities. Use the rating scale where “0” indicates that pain does not interfere and “10” indicates that pain completely interferes.

- |  |                             |                             |                             |                             |                             |                             |                             |                             |                             |                             |                              |
|--|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|------------------------------|
| General activities   | <input type="checkbox"/> _0 | <input type="checkbox"/> _1 | <input type="checkbox"/> _2 | <input type="checkbox"/> _3 | <input type="checkbox"/> _4 | <input type="checkbox"/> _5 | <input type="checkbox"/> _6 | <input type="checkbox"/> _7 | <input type="checkbox"/> _8 | <input type="checkbox"/> _9 | <input type="checkbox"/> _10 |
| Mood   | <input type="checkbox"/> _0 | <input type="checkbox"/> _1 | <input type="checkbox"/> _2 | <input type="checkbox"/> _3 | <input type="checkbox"/> _4 | <input type="checkbox"/> _5 | <input type="checkbox"/> _6 | <input type="checkbox"/> _7 | <input type="checkbox"/> _8 | <input type="checkbox"/> _9 | <input type="checkbox"/> _10 |
| Walking ability  | <input type="checkbox"/> _0 | <input type="checkbox"/> _1 | <input type="checkbox"/> _2 | <input type="checkbox"/> _3 | <input type="checkbox"/> _4 | <input type="checkbox"/> _5 | <input type="checkbox"/> _6 | <input type="checkbox"/> _7 | <input type="checkbox"/> _8 | <input type="checkbox"/> _9 | <input type="checkbox"/> _10 |
| Normal work (includes work outside the home and housework) | <input type="checkbox"/> _0 | <input type="checkbox"/> _1 | <input type="checkbox"/> _2 | <input type="checkbox"/> _3 | <input type="checkbox"/> _4 | <input type="checkbox"/> _5 | <input type="checkbox"/> _6 | <input type="checkbox"/> _7 | <input type="checkbox"/> _8 | <input type="checkbox"/> _9 | <input type="checkbox"/> _10 |
| Relations with other people                                | <input type="checkbox"/> _0 | <input type="checkbox"/> _1 | <input type="checkbox"/> _2 | <input type="checkbox"/> _3 | <input type="checkbox"/> _4 | <input type="checkbox"/> _5 | <input type="checkbox"/> _6 | <input type="checkbox"/> _7 | <input type="checkbox"/> _8 | <input type="checkbox"/> _9 | <input type="checkbox"/> _10 |
| Sleep  | <input type="checkbox"/> _0 | <input type="checkbox"/> _1 | <input type="checkbox"/> _2 | <input type="checkbox"/> _3 | <input type="checkbox"/> _4 | <input type="checkbox"/> _5 | <input type="checkbox"/> _6 | <input type="checkbox"/> _7 | <input type="checkbox"/> _8 | <input type="checkbox"/> _9 | <input type="checkbox"/> _10 |
| Enjoyment of life  | <input type="checkbox"/> _0 | <input type="checkbox"/> _1 | <input type="checkbox"/> _2 | <input type="checkbox"/> _3 | <input type="checkbox"/> _4 | <input type="checkbox"/> _5 | <input type="checkbox"/> _6 | <input type="checkbox"/> _7 | <input type="checkbox"/> _8 | <input type="checkbox"/> _9 | <input type="checkbox"/> _10 |

The next series of questions is designed to help us better understand how your **neck** pain affects your ability to manage everyday activities.

Please mark in each section the *one choice* that applies to you. Although you may consider that two of the statements in any one section relate to you please mark the choice that *most closely* describes your present-day situation.

Pain Intensity

- <sub>0</sub> I have no pain at the moment.
- <sub>1</sub> The pain is very mild at the moment.
- <sub>2</sub> The pain is moderate at the moment.
- <sub>3</sub> The pain is fairly severe at the moment.
- <sub>4</sub> The pain is very severe at the moment.
- <sub>5</sub> The pain is the worst imaginable at the moment.

Personal Care

- <sub>0</sub> I can look after myself normally without causing extra pain.
- <sub>1</sub> I can look after myself normally but it causes extra pain.
- <sub>2</sub> It is painful to look after myself and I am slow and careful.
- <sub>3</sub> I need some help but manage most of my personal care.
- <sub>4</sub> I need help every day in most aspects of self-care.
- <sub>5</sub> I do not get dressed. I wash with difficulty and stay in bed.

Lifting

- <sub>0</sub> I can lift heavy weights without causing extra pain.
- <sub>1</sub> I can lift heavy weights but it gives me extra pain.
- <sub>2</sub> Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned ie. on a table.
- <sub>3</sub> Pain prevents me from lifting heavy weights but I can manage light weights if they are conveniently positioned.
- <sub>4</sub> I can lift only very light weights.
- <sub>5</sub> I cannot lift or carry anything at all.

Work

- <sub>0</sub> I can do as much work as I want.
- <sub>1</sub> I can only do my usual work; but no more.
- <sub>2</sub> I can do most of my usual work; but no more.
- <sub>3</sub> I can't do my usual work.
- <sub>4</sub> I can hardly do any work at all.
- <sub>5</sub> I can't do any work at all.

Headaches

- <sub>0</sub> I have no headaches at all.
- <sub>1</sub> I have slight headaches that come infrequently.
- <sub>2</sub> I have moderate headaches that come infrequently.
- <sub>3</sub> I have moderate headaches that come frequently.
- <sub>4</sub> I have severe headaches that come frequently.
- <sub>5</sub> I have headaches almost all the time.

Concentration

- <sub>0</sub> I can concentrate fully without difficulty.
- <sub>1</sub> I can concentrate fully with slight difficulty.
- <sub>2</sub> I have a fair degree of difficulty concentrating.
- <sub>3</sub> I have a lot of difficulty concentrating.
- <sub>4</sub> I have a great deal of difficulty concentrating.
- <sub>5</sub> I can't concentrate at all.

- Sleeping
- <sub>0</sub> Pain does not prevent me from sleeping well.
  - <sub>1</sub> I can sleep well only by using tablets.
  - <sub>2</sub> Even when I take tablets I have less than 6 hours sleep.
  - <sub>3</sub> Even when I take tablets I have less than 4 hours sleep.
  - <sub>4</sub> Even when I take tablets I have less than 2 hours sleep.
  - <sub>5</sub> Pain prevents me from sleeping at all.
- Driving
- <sub>0</sub> I can drive my car without neck pain.
  - <sub>1</sub> I can drive as long as I want with slight neck pain.
  - <sub>2</sub> I can drive as long as I want with moderate neck pain.
  - <sub>3</sub> I can't drive as long as I want because of moderate neck pain.
  - <sub>4</sub> I can hardly drive at all because of severe neck pain.
  - <sub>5</sub> I can't drive my car at all because of neck pain.
- Reading
- <sub>0</sub> I can read as much as I want with no neck pain.
  - <sub>1</sub> I can read as much as I want with slight neck pain.
  - <sub>2</sub> I can read as much as I want with moderate neck pain.
  - <sub>3</sub> I can't read as much as I want because of moderate neck pain.
  - <sub>4</sub> I can't read as much as I want because of severe neck pain.
  - <sub>5</sub> I can't read at all.
- Recreation
- <sub>0</sub> I have no neck pain during all recreational activities.
  - <sub>1</sub> I have some neck pain during all recreational activities.
  - <sub>2</sub> I have some neck pain with a few recreational activities.
  - <sub>3</sub> I have neck pain with most recreational activities.
  - <sub>4</sub> I can hardly do any recreational activities due to neck pain.
  - <sub>5</sub> I can't do any recreational activities due to neck pain.

The next series of questions asks for your views about your health. For each of the following questions, please select an item that best describes your answer.

- In general, would you say your health is
- <sub>1</sub> Excellent
  - <sub>2</sub> Very good
  - <sub>3</sub> Good
  - <sub>4</sub> Fair
  - <sub>5</sub> Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities and, if so, how much?

- Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
- Climbing several flights of stairs
- <sub>1</sub> No not limited at all      <sub>2</sub> Yes limited a little      <sub>3</sub> Yes limited a lot

During the past four weeks, how much of the time have you had any of the following problems with your work or other daily activities as a result of your physical health?

- Accomplished less than you would like
- Were limited in the kind of work or other activities
- <sub>1</sub> All of the time      <sub>2</sub> Most of the time      <sub>3</sub> Some of the time      <sub>4</sub> A little of the time      <sub>5</sub> None of the time

During the past four weeks, how much of the time have you had any of the following problems with your work or other daily activities as a result of your emotional health (such as feeling depressed or anxious)?

- Accomplished less than you would like
- Were limited in the kind of work or other activities
- <sub>1</sub> All of the time      <sub>2</sub> Most of the time      <sub>3</sub> Some of the time      <sub>4</sub> A little of the time      <sub>5</sub> None of the time

- How much did pain interfere with your normal work (including both work outside the home and housework)
- <sub>1</sub> Not at all      <sub>2</sub> A little bit      <sub>3</sub> Moderately      <sub>4</sub> Quite a bit      <sub>5</sub> Extremely

These questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the one answer that comes closest to the way that you have been feeling. How much of the time during the past for weeks ...

- Did you feel calm and peaceful?
- Did you have a lot of energy?
- Have you felt downhearted and depressed?
- How much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc)
- <sub>1</sub> All of the time      <sub>2</sub> Most of the time      <sub>3</sub> Some of the time      <sub>4</sub> A little of the time      <sub>5</sub> None of the time

With regard to your **neck** condition during the last week, please select the one response for each question that best applies. If your condition varies depending on the day or the time, select the one response that applies for your condition at its worst.

While in the sitting position, can you look up at the ceiling by tilting your head upward?

- <sub>1</sub> Impossible
- <sub>2</sub> Possible to some degree (with some effort)
- <sub>3</sub> Possible without difficulty

Can you drink a glass of water without stopping despite your neck symptoms?

- <sub>1</sub> Impossible
- <sub>2</sub> Possible to some degree (with some effort)
- <sub>3</sub> Possible without difficulty

While in the sitting position, can you turn your head toward the person who is seated to the side but behind you and speak to that person while looking at his or her face?

- <sub>1</sub> Impossible
- <sub>2</sub> Possible to some degree (with some effort)
- <sub>3</sub> Possible without difficulty

Can you look at your feet when you go down the stairs?

- <sub>1</sub> Impossible
- <sub>2</sub> Possible to some degree (with some effort)
- <sub>3</sub> Possible without difficulty

Can you fasten the front buttons of your blouse or shirt with both hands?

- <sub>1</sub> Impossible
- <sub>2</sub> Possible if I spend some time
- <sub>3</sub> Possible without difficulty

Can you eat a meal with your dominant hand using a spoon or a fork?

- <sub>1</sub> Impossible
- <sub>2</sub> Possible if I spend some time
- <sub>3</sub> Possible without difficulty

Can you raise your arm? (Answer for the weaker side)

- <sub>1</sub> Impossible
- <sub>2</sub> Possible up to shoulder level
- <sub>3</sub> Possible, though the elbow and/or wrist is a little flexed
- <sub>4</sub> I can raise it straight upward

Can you walk on a flat surface

- <sub>1</sub> Impossible
- <sub>2</sub> Possible but slowly even with support
- <sub>3</sub> Possible only with support of a handrail, cane, or walker
- <sub>4</sub> Possible but slowly without any support
- <sub>5</sub> Possible without difficulty

Can you stand on either leg without the support of your hand? (The need to support yourself)

- <sub>1</sub> Impossible with either leg
- <sub>2</sub> Possible on either leg for more than ten seconds
- <sub>3</sub> Possible on both legs individually for more than ten seconds

Do you have difficulty going up the stairs?

- <sub>1</sub> I have great difficulty
- <sub>2</sub> I have some difficulty
- <sub>3</sub> I have no difficulty

Do you have difficulty in one of the following motions: bending forward, kneeling, or stooping?

- <sub>1</sub> I have great difficulty
- <sub>2</sub> I have some difficulty
- <sub>3</sub> I have no difficulty

Do you have difficulty in walking for more than 15 minutes

- <sub>1</sub> I have great difficulty
- <sub>2</sub> I have some difficulty
- <sub>3</sub> I have no difficulty

Do you have urinary incontinence? <sub>1</sub> Always  
<sub>2</sub> Frequently  
<sub>3</sub> When retaining urine over a period of more than 2 hours  
<sub>4</sub> When sneezing or straining  
<sub>5</sub> No

How often do you go to the bathroom at night? <sub>1</sub> Three or more times  
<sub>2</sub> Once or twice  
<sub>3</sub> Rarely

Do you have a feeling of residual urine in your bladder after voiding? <sub>1</sub> Most of the time  
<sub>2</sub> Some of the time  
<sub>3</sub> Rarely

Can you initiate (start) your urine stream immediately when you want to void? <sub>1</sub> Usually not  
<sub>2</sub> Sometimes  
<sub>3</sub> Most of the time

How is your present health? <sub>1</sub> Poor  
<sub>2</sub> Fair  
<sub>3</sub> Good  
<sub>4</sub> Very Good  
<sub>5</sub> Excellent

Have you been unable to do your work or ordinary activities as well as you would like? <sub>1</sub> I have been unable to do them at all  
<sub>2</sub> I have been unable to do them most of the time  
<sub>3</sub> I have sometimes been unable to do them  
<sub>4</sub> I have been able to do them most of the time  
<sub>5</sub> I have always been able to do them

Has your work routine been hindered because of the pain? <sub>1</sub> Greatly  
<sub>2</sub> Moderately  
<sub>3</sub> Slightly (somewhat)  
<sub>4</sub> Little (minimally)  
<sub>5</sub> Not at all

Have you been discouraged or depressed? <sub>1</sub> Always  
<sub>2</sub> Frequently  
<sub>3</sub> Sometimes  
<sub>4</sub> Rarely  
<sub>5</sub> Never

Do you feel exhausted? <sub>1</sub> Always  
<sub>2</sub> Frequently  
<sub>3</sub> Sometimes  
<sub>4</sub> Rarely  
<sub>5</sub> Never

Have you felt happy? <sub>1</sub> Always  
<sub>2</sub> Frequently  
<sub>3</sub> Sometimes  
<sub>4</sub> Rarely  
<sub>5</sub> Never

Do you think that you are in decent health?

- <sub>1</sub> Not at all (my health is very poor)
- <sub>2</sub> Barely (my health is poor)
- <sub>3</sub> Not very much (my health is average)
- <sub>4</sub> Fairly (my health is better than average)
- <sub>5</sub> Yes (I am healthy)

Do you feel that your health will get worse?

- <sub>1</sub> Very much so
- <sub>2</sub> A little bit at a time
- <sub>3</sub> Sometimes yes and sometimes no
- <sub>4</sub> Not very much
- <sub>5</sub> Not at all

Regarding 0 as “no pain (numbness) at all” and 10 as “the most intense pain (numbness) imaginable”, choose a number between 0 and 10 to show the degree of pain (numbness) when your symptom is at its worst during the last week.

If you feel pain or stiffness in your neck or shoulders, mark the degree

- <sub>0</sub>
- <sub>1</sub>
- <sub>2</sub>
- <sub>3</sub>
- <sub>4</sub>
- <sub>5</sub>
- <sub>6</sub>
- <sub>7</sub>
- <sub>8</sub>
- <sub>9</sub>
- <sub>10</sub>

If you feel tightness in your chest, mark the degree

- <sub>0</sub>
- <sub>1</sub>
- <sub>2</sub>
- <sub>3</sub>
- <sub>4</sub>
- <sub>5</sub>
- <sub>6</sub>
- <sub>7</sub>
- <sub>8</sub>
- <sub>9</sub>
- <sub>10</sub>

If you feel pain or numbness in your arms or hands, mark the degree

- <sub>0</sub>
- <sub>1</sub>
- <sub>2</sub>
- <sub>3</sub>
- <sub>4</sub>
- <sub>5</sub>
- <sub>6</sub>
- <sub>7</sub>
- <sub>8</sub>
- <sub>9</sub>
- <sub>10</sub>

If you feel pain or numbness from chest to toe, mark the degree

- <sub>0</sub>
- <sub>1</sub>
- <sub>2</sub>
- <sub>3</sub>
- <sub>4</sub>
- <sub>5</sub>
- <sub>6</sub>
- <sub>7</sub>
- <sub>8</sub>
- <sub>9</sub>
- <sub>10</sub>

The next series of statements ask for your views about your swallowing ability. *If you do not have a swallowing problem, proceed to Page 11.*

The following statements have been made by people who have problems with their swallowing. Some of the statements may apply to you. Please read each statement and select the response that best reflects your experience in the past week.

My swallowing limits my day-to-day activities.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
I am embarrassed by my eating habits.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
People have difficulty cooking for me.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
Swallowing is more difficult at the end of the day.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
I do not feel self-conscious when I eat.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
I am upset by my swallowing problem.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
Swallowing takes great effort.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
I do not go out because of my swallowing problem.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
It takes me longer to eat because of my swallowing problem.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
People ask me, "Why can't you eat that?"	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
Other people are irritated by my eating problem.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
I cough when I try to drink liquid.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
My swallowing problems limit my social and personal life.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
I feel free to go out to eat with my friends, neighbors, and relatives.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
I limit my food intake because of my swallowing difficulty.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree
I cannot maintain my weight because of my swallowing difficulty.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> No opinion	<input type="checkbox"/> <sub>4</sub> Disagree	<input type="checkbox"/> <sub>5</sub> Strongly disagree

I have low self esteem because of my swallowing problems.    <sub>1</sub> Strongly agree    <sub>2</sub> Agree    <sub>3</sub> No opinion    <sub>4</sub> Disagree    <sub>5</sub> Strongly disagree

I feel that I am swallowing a huge amount of food.    <sub>1</sub> Strongly agree    <sub>2</sub> Agree    <sub>3</sub> No opinion    <sub>4</sub> Disagree    <sub>5</sub> Strongly disagree

I feel excluded because of my eating habits.    <sub>1</sub> Strongly agree    <sub>2</sub> Agree    <sub>3</sub> No opinion    <sub>4</sub> Disagree    <sub>5</sub> Strongly disagree

Below are some statements that people make when talking about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally. Your answers should be true to you and not what you think your doctor wants to hear.

When all is said and done, I am the person responsible for my health condition(s)	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree
Taking an active role in my own health is the most important factor in determining my health and ability to function.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree
I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition(s).	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree
I know what each of my prescribed medications do.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree
I am confident that I can tell when I need to go get medical care and when I can handle a health problem on my own.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree
I am confident that I can tell a doctor concerns I have even when he or she does not ask.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree
I am confident that I can follow through on medical treatments that I need to do at home.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree
I understand the nature and causes of my health condition(s).	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree
I know the different medical treatment options available for my health condition(s).	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree
I have been able to maintain the lifestyle changes for my health condition(s) that I have made.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree
I know how to prevent further problems with my health condition(s).	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree
I am confident that I can figure out solutions when new situations or problems arise with my health condition(s).	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree
I am confident that I can maintain lifestyle changes, like diet and exercise, even during times of stress.	<input type="checkbox"/> <sub>1</sub> Strongly agree	<input type="checkbox"/> <sub>2</sub> Agree	<input type="checkbox"/> <sub>3</sub> Disagree	<input type="checkbox"/> <sub>4</sub> Strongly disagree

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Feeling nervous, anxious, or on edge	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Not being able to sleep or control worrying	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Worrying too much about different things	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Trouble relaxing	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Being so restless that it is hard to sit still	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Becoming easily annoyed or irritated	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Feeling afraid, as if something awful might happen	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day

If you checked off any problems in the table above, how difficult have these problems made it for you to do your work, take care of things, or get along with other people?

- <sub>1</sub> Not difficult at all
- <sub>2</sub> Somewhat difficult
- <sub>3</sub> Very difficult
- <sub>4</sub> Extremely difficult

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Feeling down, depressed, or hopeless	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Feeling tired or having little energy	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Poor appetite or overeating	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day
Moving or speaking so slowly that other people could have notices? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/> <sub>1</sub> Not at all	<input type="checkbox"/> <sub>2</sub> Several days	<input type="checkbox"/> <sub>3</sub> Over half the days	<input type="checkbox"/> <sub>4</sub> Nearly every day

If you checked off any problems in the table above, how difficult have these problems made it for you to do your work, take care of things, or get along with other people?

- <sub>1</sub> Not difficult at all
- <sub>2</sub> Somewhat difficult
- <sub>3</sub> Very difficult
- <sub>4</sub> Extremely difficult

**Pain interference**

In the past 7 days ...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
How much did pain interfere with your enjoyment of life?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
How much did pain interfere with your ability to concentrate?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
How much did pain interfere with your day to day activities?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
How much did pain interfere with your enjoyment of recreational activities?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
How much did pain interfere with doing your tasks away from home (e.g. getting groceries, running errands)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
In the past 7 days ...	Never	Rarely	Sometimes	Often	Always
How often did pain keep you from socializing with others?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**Physical function**

In the past 7 days ...

	Not at all	Very little	Somewhat	Quite a lot	Cannot do
Does your health now limit you in doing vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Does your health now limit you in walking more than a mile?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Does your health now limit you in climbing one flight of stairs?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Does your health now limit you in lifting or carrying groceries?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Does your health now limit you in bending, kneeling, or stooping?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**Physical function**

In the past 7 days ...

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to do chores such as vacuuming or yard work?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Are you able to dress yourself, including tying shoelaces and doing buttons?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Are you able to shampoo your hair?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Are you able to wash and dry your body?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Are you able to get on and off the toilet?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**Emotional Distress - Anxiety**

In the past 7 days ...

	Never	Rarely	Sometimes	Often	Always
I felt fearful	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I felt anxious	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I felt worried	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I found it hard to focus on anything other than my anxiety	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I felt nervous	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I felt uneasy	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I felt tense	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

## Emotional Distress - Depression

In the past 7 days ...

	Never	Rarely	Sometimes	Often	Always
I felt worthless	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I felt that I had nothing to look forward to	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I felt helpless	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I felt sad	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I felt like a failure	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I felt depressed	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I felt unhappy	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I felt hopeless	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

## Fatigue

In the past 7 days ...

	Never	Rarely	Sometimes	Often	Always
How often did you feel tired?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
How often did you experience extreme exhaustion?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
How often did you run out of energy?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
How often did fatigue limit you at work (include work at home)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
How often were you too tired to think clearly	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
How often were you too tired to take a bath or shower?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
How often did you have enough energy to exercise strenuously?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**Sleep Disturbance**

In the past 7 days ...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was restless	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I was satisfied with my sleep	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
My sleep was refreshing	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I had difficulty falling asleep	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
In the past 7 days ....	Never	Rarely	Sometimes	Often	Always
I had trouble staying asleep	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I had trouble sleeping	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I got enough sleep	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
In the past 7 days ....	Very poor	Poor	Fair	Good	Very good
My sleep quality was	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**Satisfaction with participation in social roles**

In the past 7 days ...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I am satisfied with my ability to do things for my family	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I am satisfied with my ability to meet the needs of those who depend on me	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I am satisfied with my ability to perform my daily routines	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I am satisfied with my ability to run errands	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I am satisfied with my ability to work (include work at home)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I am satisfied with my ability to do household chores/tasks	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
I am satisfied with how much work I can do (include work at home)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>