

# Health Assessment Questionnaire

STANFORD UNIVERSITY SCHOOL OF MEDICINE, DIVISION OF IMMUNOLOGY AND RHEUMATOLOGY

Name

Date

This questionnaire is designed to help us assess how your illness affects your ability to function in daily life. Please feel free to add any additional comments on the back of this page.

Please mark "x" in the response that best describes your usual abilities OVER THE PAST WEEK:

## DRESSING AND GROOMING

Are you able to: -Dress yourself, including tying shoelaces and doing buttons? - Shampoo your hair?

	<i>Without ANY difficulty (0)</i>	<i>With SOME difficulty (1)</i>	<i>With MUCH difficulty (2)</i>	<i>Unable to do (3)</i>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## ARISING

Are you able to: -Stand up from a straight chair? -Get in and out of bed?

	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## EATING

Are you able to: -Cut your meat? -Lift a full cup or glass to your mouth? -Open a new milk carton?

	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## WALKING

Are you able to: -Walk outdoors on flat ground? -Climb up five steps?

	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please mark "x" in any AIDS or DEVICES that you usually use for any of these activities:

- |                                |  |  |  |
|--------------------------------|--|--|--|
| <input type="radio"/> Cane     | <input type="radio"/> Wheelchair   | <input type="radio"/> Built-up or special utensils | <input type="radio"/> Other (Specify): |
| <input type="radio"/> Walker   | <input type="radio"/> Devices used for dressing (button hook, zipper pull, long shoe horn, etc.) | <input type="radio"/> Special or built-up chair    |  |
| <input type="radio"/> Crutches |  |  |  |

Please mark "x" in any categories for which you usually need HELP FROM ANOTHER PERSON:

Dressing and grooming  Arising  Eating  Walking

Continued on other side

THIS COLUMN FOR PHYSICIAN USE ONLY

HIGHEST SCORE

SUBTOTAL

Bring to of next page

Name

Please mark "x" in the response that best describes your usual abilities OVER THE PAST WEEK:

Without ANY difficulty (0)  
With SOME difficulty (1)  
With MUCH difficulty (2)  
Unable to do (3)

HYGIENE

- Are you able to: -Wash and dry your body? -
- Take a tub bath?
- Get on and off the toilet?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

REACH

- Are you able to: -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?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

GRIP

- Are you able to: -Open car doors?
- Open jars which have been previously opened?
- Turn faucets on and off?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ACTIVITIES

- Are you able to: -Run errands and shop? -
- Get in and out of a car?
- Do chores such as vacuuming or yardwork?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please mark "x" in any AIDS OR DEVICES that you usually use for any of these activities:

- Raised toilet seat  Bathtub bar  Other (Specify):
- Bathtub seat  Long-handled appliances for reach
- Jar opener  Long-handled appliances in bathroom (for jars previously opened)

Please mark "x" in any categories for which you usually need HEIP FROM ANOTHER PERSON:

- Hygiene  Reach  Gripping and opening things  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:

NO PAIN

SEVERE PAIN

PLACE A VERTICAL ( | ) MARK ON THE LINE TO INDICATE THE SEVERITY OF THE PAIN