

# Multi-Dimensional Health Assessment Questionnaire (R811-NP4)

**This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. There are no right or wrong answers.**

**1. Please check (✓) the ONE best answer for your abilities at this time:**

|  | Without<br><b>ANY</b><br>Difficulty | With<br><b>SOME</b><br>Difficulty | With<br><b>MUCH</b><br>Difficulty | <b>UNABLE</b><br>To Do |
|--|-------------------------------------|-----------------------------------|-----------------------------------|------------------------|
| <b>OVER THE LAST WEEK,</b> were you able to:   |                                     |                                   |                                   |                        |
| a. Dress yourself, including tying shoelaces and doing buttons?                      | _____0                              | _____1                            | _____2                            | _____3                 |
| b. Get in and out of bed?  | _____0                              | _____1                            | _____2                            | _____3                 |
| c. Lift a full cup to your mouth?  | _____0                              | _____1                            | _____2                            | _____3                 |
| d. Walk outdoors on flat ground?   | _____0                              | _____1                            | _____2                            | _____3                 |
| e. Wash and dry your entire body?  | _____0                              | _____1                            | _____2                            | _____3                 |
| f. Bend down to pick up items from the floor?  | _____0                              | _____1                            | _____2                            | _____3                 |
| g. Turn regular faucets on and off?  | _____0                              | _____1                            | _____2                            | _____3                 |
| h. Get in and out of a vehicle?  | _____0                              | _____1                            | _____2                            | _____3                 |
| i. Walk two miles, if you wish?  | _____0                              | _____1                            | _____2                            | _____3                 |
| j. Participate in recreational activities and sports as you would like, if you wish? | _____0                              | _____1                            | _____2                            | _____3                 |
| k. Get a good night's sleep?   | _____0                              | _____1.1                          | _____2.2                          | _____3.3               |
| l. Deal with feelings of anxiety or being nervous?                                   | _____0                              | _____1.1                          | _____2.2                          | _____3.3               |
| m. Deal with feelings of depression or feeling blue?                                 | _____0                              | _____1.1                          | _____2.2                          | _____3.3               |

**FOR OFFICE USE ONLY**

1.a-j FN (0-10):

1=0.3    16=5.3  
2=0.7    17=5.7  
3=1.0    18=6.0  
4=1.3    19=6.3  
5=1.7    20=6.7  
6=2.0    21=7.0  
7=2.3    22=7.3  
8=2.7    23=7.7  
9=3.0    24=8.0  
10=3.3    25=8.3  
11=3.7    26=8.7  
12=4.0    27=9.0  
13=4.3    28=9.3  
14=4.7    29=9.7  
15=5.0    30=10

2.PN (0-10):

3.PTGL (0-10):

RAPID 3 (0-30)

Cat:

HS = >12

MS = 6.1-12

LS = 3.1-6

R = ≤3

**2. How much pain have you had because of your condition OVER THE PAST WEEK?**

**Please indicate below how severe your pain has been:**

NO PAIN AS BAD  
PAIN 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 IT COULD BE

**3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:**

VERY VERY  
WELL 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 POORLY

**4. Please check (✓) if you have experienced any of the following over the last month:**

|                              |                                 |                                      |
|------------------------------|---------------------------------|--------------------------------------|
| Fever                        | Lump in your throat             | Paralysis of arms or legs            |
| Weight gain (>10 lbs)        | Cough                           | Numbness or tingling of arms or legs |
| Weight loss (>10 lbs)        | Shortness of breath             | Fainting spells                      |
| Feeling sickly               | Wheezing                        | Swelling of hands                    |
| Headaches                    | Pain in the chest               | Swelling of ankles                   |
| Unusual fatigue              | Heart pounding (palpitations)   | Swelling in other joints             |
| Swollen glands               | Trouble swallowing              | Joint pain                           |
| Loss of appetite             | Heartburn or stomach gas        | Back pain                            |
| Skin rash or hives           | Stomach pain or cramps          | Neck pain                            |
| Unusual bruising or bleeding | Nausea                          | Use of drugs not sold in stores      |
| Other skin problems          | Vomiting                        | Smoking cigarettes                   |
| Loss of hair                 | Constipation                    | More than 2 alcoholic drinks per day |
| Dry eyes                     | Diarrhea                        | Depression - feeling blue            |
| Other eye problems           | Dark or bloody stools           | Anxiety - feeling nervous            |
| Problems with hearing        | Problems with urination         | Problems with thinking               |
| Ringing in the ears          | Gynecological (female) problems | Problems with memory                 |
| Stuffy nose                  | Dizziness                       | Problems with sleeping               |
| Sores in the mouth           | Losing your balance             | Sexual problems                      |
| Dry mouth                    | Muscle pain, aches, or cramps   | Burning in sex organs                |
| Problems with smell or taste | Muscle weakness                 | Problems with social activities      |

**Name:** \_\_\_\_\_ **D.O.B** \_\_\_\_\_ **Date:** \_\_\_\_\_