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Update November 17, 2022

Part I

Introduction

1. MMPI -
   a. https://www.pearsonassessments.com/tests/mmpi_2.htm and http://down-load.cnet.com/s/mmpi/
2. PAI - Personality Assessment Inventory
   a. https://www.wpspublish.com/store/p/2893/pai-personality-assessment-inventory
3. ACE Scale – Adverse Childhood Events
   i. 'when it's not one thing, it's your mother'
4. Life Events Scale
5. Quick Burnout Assessment
6. WRSQ Work Related Stress Questionnaire

Substance Use Disorders

7. Audit-C Questionnaire – Alcohol Use
8. Alcohol Withdrawal CIWA Scale
9. Risk Assessment, Chronic Opioid Treatment - SOAPP-R
10. Clinical Opioid Withdrawal Scale

Global Pain Measures

11. Pain Analog Scale
12. Ransford Pain Drawing & Scoring
13. BPI - Brief Pain Inventory – Cancer Pain
14. Oswestry Low Back Disability Questionnaire
15. McGill Pain Questionnaire
16. Öresbro Musculoskeletal Pain Questionnaire
17. CRPS Criteria – Budapest

Organ Function

18. Sino-Nasal Outcome Test SNOT-22
19. Cardiomyopathy Questionnaire
20. Eczema Patient Oriented Measures POEMS
21. Gastro-intestinal Rating Scale
22. Bowel Control Scales
23. Bladder Control Scales
24. Male Sexual Function Questionnaires - IIES 5 & IIES 6
25. Female Sexual Function Index FSFI
26. Pelvic Pain Questionnaire NHI-CPSI

Infectious Diseases & Covid

27. Covid Risk Assessment
28. Post-Covid Cough
29. STD Risk Assessment Simple
30. STD Risk Assessment HHS
31. HIV Risk Assessment
32. Monkeypox Post-Exposure Algorithm

Part II

Regional Pain Assessment

33. REBA Employee Assessment Worksheet
34. Neck Disability Index
35. Oxford Shoulder Score
36. Oxford Shoulder Instability Score
37. Simple Shoulder Test
38. https://www.orthopaedicscore.com – QuickDash Shoulder, etc.
39. Boston Carpal Tunnel Questionnaire & Diagram
40. Back Screening Tool - Keele STarT
41. Harris Hip Score
42. Koos Knee Survey

Neuropsychiatric Assessment

43. Concussion: Head Injury Symptom Scale
44. Headache Disability Index
45. Head Injury Daily Checklist
46. Michigan Neuropathy Screening Instrument
47. Scripps Neurological Rating Scale
48. Folstein Mini-Mental State Evaluation
49. SLUMS Examination
50. MOCA Test

Part III

Functional Disorder Assessment

51. Fatigue Inventory - MFT Multidimensional
52. Fatigue Severity Scale
53. Fibromyalgia 2011 ACR Criteria
54. Fibromyalgia Impact Questionnaire
55. Rheumatoid Arthritis v. Fibromyalgia
56. Idiopathic Environmental Intolerance Inventory
57. Environmental Assessment
58. PHQ-15 - Somatization Symptom Severity Scale & Scoring
59. Stop-Bang Sleep Apnea Questionnaire
60. Epworth Sleepiness Scale

Psychiatric Assessment

61. Mental Health Continuum Self-Check
62. BRPS Brief Psychiatric Rating Scale
63. ADHA – ASRS Questionnaire
64. ADHD Self Report Scale
65. PTSD Documentation – PC-PTSD
66. Body Sensation Questionnaire
67. General Anxiety Tool
68. Whiteley Index 7 (Malingering)
69. Eating Disorder Questionnaire SCOFF
70. PHQ-9 Depression Scale
71. Zung Depression Scale & Scoring
72. Hamilton Depression Scale
73. Edinburgh Postnatal Depression Scale
74. Geriatric Depression Scale
75. Columbia Suicide Severity Rating Scale

Part IV

Impact Assessment

76. Fear Avoidance Beliefs Questionnaire
77. PDQ Pain Disability Questionnaire
78. ACPA Quality of Life Scale
79. Barthel Index of Activities of Daily Living
80. ADL Index
81. Activities of Daily Living, AMA Guides
82. Simple Mental Status Questionnaire
83. CDR Clinical Dementia Rating
84. Functional Activities Questionnaire for the Elderly
85. Katz Index of Independence
86. Expanded Disability Status Scale (EDSS) [Multiple Sclerosis]
87. Rate of Perceived Exertion (RPE) and Borg Scale
88. Six Minute Walk
89. Tinetti Gait & Balance Assessment
90. Elderly Mobility Assessment
91. Fall Risk Assessment
92. Fall Risk Hendrich II
93. Braden Scale – Pressure Sores
94. Global Functioning Scale, AMA Guides 6th Edition
95. Karnofsky Performance Scale
96. Sequential Organ Failure Assessment SOFA

Work Performance

97. Supervisor Checklist, Acute Impairment
98. Supervisor Checklist, Chronic Impairment

Split package for e-mail transfer

Part I	Tools # 1 – 32	Global Measures, Pain Assessment, Organ Measures
Part II	Tools # 33 – 50	Orthopedic Scales, Neuropsychiatric Instruments
Part III	Tools # 51 – 75	Functional & Psychiatric Disorders
Part IV	Tools # 76 – 98	Impact Assessment, Supervisor's Checklists

Outpatient Mental Health Interpretive Report

MMPI®-2

The Minnesota Report™: Adult Clinical System-Revised, 4th Edition

James N. Butcher, PhD

Name:

ID Number:

Age:

Gender:

Marital Status:

Years of Education:

Date Assessed:

PEARSON

PsychCorp

[9.4/1/2.4.8]

For reference only

PERSONALITY ASSESSMENT INVENTORY™

Clinical Interpretive Report

by

Leslie C. Morey, PhD
and PAR Staff

Client Information

Client Name	:	C.C.
Client ID	:	-Not Specified-
Age	:	-Not Specified-
Gender	:	Male
Education	:	-Not Specified-
Marital Status	:	-Not Specified-
Test Date	:	-Not Specified-
Prepared For	:	-Not Specified-

The interpretive information contained in this report should be viewed as only one source of hypotheses about the individual being evaluated. No decisions should be based solely on the information contained in this report. This material should be integrated with all other sources of information in reaching professional decisions about this individual.

This report is confidential and intended for use by qualified professionals only. It should not be released to the individual being evaluated.

Adverse Childhood Experience Survey		
QUESTION	**Yes**	**No**
Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?		
Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?		
Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?		
Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?		
Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
Were your parents ever separated or divorced?		
Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?		
Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?		
Was a household member depressed or mentally ill, or did a household member attempt suicide?		
Did a household member go to prison?		
Add up your "yes" answers – that's your ACES score		

The social readjustment rating scale*

Directions. Read each life event and indicate in the space provided the number of times you have experienced the event in the last year. Multiply the number of times you experienced the event by the points next to it and total up the products.

Life event	Stress value	Number of times you experienced the event last year	Your total life change scores
1) Death of spouse	100	×	=
2) Divorce	73	×	=
3) Marital separation from mate	65	×	=
4) Detention in jail or other institution	63	×	=
5) Death of a close family member	63	×	=
6) Major personal injury or illness	53	×	=
7) Marriage	50	×	=
8) Being fired from work	47	×	=
9) Marital reconciliation with mate	45	×	=
10) Retirement from work	45	×	=
11) Major change in the health or behavior of a family member	44	×	=
12) Pregnancy	40	×	=
13) Sexual difficulties	39	×	=
14) Gaining a new family member (e.g. through birth, adoption, oldster moving in, etc.)	39	×	=
15) Major business readjustment (e.g. merger, reorganization, bankruptcy, etc.)	39	×	=
16) Major change in financial state (e.g. a lot worse off or a lot better off than usual)	38	×	=
17) Death of a close friend	37	×	=
18) Changing to a different line of work	36	×	=
19) Major change in the number of arguments with spouse (e.g. either a lot more or a lot less than usual regarding childbearing, personal habits, etc.)	35	×	=
20) Taking on a mortgage greater than $10,000 (e.g. purchasing a home, business, etc.)	31	×	=
21) Foreclosure on a mortgage or loan	30	×	=
22) Major change in responsibilities at work (e.g. promotion, demotion, lateral transfer)	29	×	=
23) Son or daughter leaving home (e.g. marriage, attending college, etc.)	29	×	=
24) Inlaw troubles	29	×	=
25) Outstanding personal achievement	28	×	=
26) Wife beginning or ceasing work outside the home	26	×	=
27) Beginning or ceasing formal schooling	26	×	=
28) Major change in living conditions (e.g. building a new home, remodeling, deterioration of home or neighborhood)	25	×	=
29) Revision of personal habits (e.g. dress, manners, associations, etc.)	24	×	=
30) Troubles with the boss	23	×	=
31) Major change in working hours or conditions	20	×	=
32) Change in residence	20	×	=
33) Changing to a new school	20	×	=
34) Major change in usual type and/or amount of recreation	19	×	=
35) Major change in church activities (e.g. a lot more or a lot less than usual	19	×	=
36) Major change in social activities (e.g. clubs, dancing, movies, visiting, etc.)	18	×	=
37) Taking on a mortgage or loan less than $10,000 (e.g. purchasing a car, TV, freezer, etc.)	17	×	=
38) Major change in sleeping habits (e.g. a lot more or a lot less sleep, or change in part of day when asleep)	16	×	=
39) Major change in number of family get-togethers (e.g. a lot more or a lot less than usual)	15	×	=
40) Major change in eating habits (e.g. a lot more or a lot less food intake, or very different meal hours or surroundings)	15	×	=
41) Vacation	13	×	=
42) Christmas	12	×	=
43) Minor violations of the law (e.g. traffic tickets, jaywalking, disturbing the peace, etc.)	11	×	=
Grand total			

Quick Burnout Assessment

To give an idea of how we assess burnout, here are a few items from our book, *"Banishing Burnout: Six Strategies for Improving Your Relationship With Work."* Please note, however, that this is not a complete survey.
For each item, think about how your current work matches up with your personal preferences, work patterns, and aspirations.

	Just Right	Mismatch	Major Mismatch
Workload			
The amount of work to complete in a day			
The frequency of surprising, unexpected events			
Control			
My participation in decisions that affect my work			
The quality of leadership from upper management			
Reward			
Recognition for achievements from my supervisor			
Opportunities for bonuses or raises			
Community			
The frequency of supportive interactions at work			
The closeness of personal friendships at work			
Fairness			
Management's dedication to giving everyone equal consideration			
Clear and open procedures for allocating rewards and promotions			
Values			
The potential of my work to contribute to the larger community			
My confidence that the organization's mission is meaningful			

- If everything is a match, you have found an excellent setting for your work
- A few mismatches are not very surprising. People are usually willing and able to tolerate them
- A lot of mismatches, and especially major mismatches in areas that are very important to you, are signs of a potentially intolerable situation

18 - 21 – moderate burnout

$\geq$ 30 – high burnout

Christina Maslach & Michael Leiter, Stanford Social Innovation Review

WORK-RELATED STRESS QUESTIONNAIRE

Instructions: It is recognised that working conditions affect worker well-being. Your responses to the questions below will help us determine our working conditions now, and enable us to monitor future improvements. In order for us to compare the current situation with past or future situations, **it is important that your responses reflect your work in the last six months**.

1.	I am clear what is expected of me at work	**Never** ☐ **1**	**Seldom** ☐ **2**	**Sometimes** ☐ **3**	**Often** ☐ **4**	**Always** ☐ **5**
2.	I can decide when to take a break	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
3.	Different groups at work demand things from me that are hard to combine	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
4.	I know how to go about getting my job done	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
5.	I am subject to personal harassment in the form of unkind words or behaviour	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
6.	I have unachievable deadlines	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
7.	If work gets difficult, my colleagues will help me	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
8.	I am given supportive feedback on the work I do	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
9.	I have to work very intensively	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
10.	I have a say in my own work speed	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
11.	I am clear what my duties and responsibilities are	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
12.	I have to neglect some tasks because I have too much to do	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
13.	I am clear about the goals and objectives for my department	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
14.	There is friction or anger between colleagues	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
15.	I have a choice in deciding how I do my work	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
16.	I am unable to take sufficient breaks	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
17.	I understand how my work fits into the overall aim of the organisation	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
18.	I am pressured to work long hours	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1

19. I have a choice in deciding what I do at work	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
20. I have to work very fast	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
21. I am subject to bullying at work	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
22. I am aware of others being subject to bullying at work	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
23. If I were aware of bullying I would feel able to challenge it	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
24. If I reported bullying, I would be confident that it would be stopped	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
25. I have unrealistic time pressures	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
26. I can rely on my line manager to help me out with a work problem	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
27. I get help and support I need from colleagues	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
28. I have some say over the way I work	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
29. I have sufficient opportunities to question managers about change at work	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
30. I receive the respect at work I deserve from my colleagues	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
31. Staff are always consulted about change at work	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
32. I can talk to my line manager about something that has upset or annoyed me about work	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
33. My working time can be flexible	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
34. My working location can be flexible (subject to business constraints)	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
35. My colleagues are willing to listen to my work-related problems	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
36. When changes are made at work, I am clear how they will work out in practice	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
37. I am supported through emotionally demanding work	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
38. Relationships at work are strained	Strongly disagree ☐ 5	Disagree ☐ 4	Neutral ☐ 3	Agree ☐ 2	Strongly agree ☐ 1
39. My line manager encourages me at work	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5

Audit-C Questionnaire

1. How often did you have a drink containing alcohol in the past year?
• Never (0 points) * If you answered Never, score questions 2 and 3 below as zero.
• Monthly or less (1 point)
• 2 to 4 times a month (2 points)
• 2 or 3 times per week (3 points)
• 4 or more times a week (4 points)

2. How many drinks did you have on a typical day when you were drinking in the past year?
• 1 – 2 (0 points)
• 3 – 4 (1point)
• 5 – 6 (2 points)
• 7 – 9 (3 points)
• 10 or more (4 points)

3. How often did you have 6 or more drinks on one occasion in the past year?
• Never (0 points)
• Less than monthly (1 point)
• Monthly (2 points)
• Weekly (3 points)
• Daily or almost daily (4 points)

The AUDIT-C (Alcohol-Use Disorders Identification Test – Consumption) is scored on a scale of 0 to 12 (a score of 0 reflects no alcohol use). A score of 3 or more in older adults is considered positive and suggests the need for further evaluation.

The Audit-C is a screening questionnaire developed by the World Health Organization. This test is unique in that it has been validated in six countries and has been used internationally. Like the CAGE, a high score suggests that you should look deeper into your substance use.

Clinical Insitutue Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ Blood pressure:_____

NAUSEA AND VOMITING — Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TREMOR — Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

PAROXYSMAL SWEATS — Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

ANXIETY — Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION — Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

TACTILE DISTURBANCES — Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning ornumbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

AUDITORY DISTURBANCES — Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

VISUAL DISTURBANCES — Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD — Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 no present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM — Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction* 84:1353-1357, 1989.

Patients scoring less than 10 do not usually need additional medication for withdrawal.

Total CIWA-Ar Score _____

Rater's Initials _____

Maximum Possible Score 67

Risk Assessment, Long Term Opioid Therapy

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

Scoring Instructions for the SOAPP®-R®

All 24 questions contained in the SOAPP®-R have been empirically identified as predicting aberrant medication-related behavior six months after initial testing.

To score the SOAPP, add the ratings of all the questions. A score of 18 or higher is considered positive.

Sum of Questions	SOAPP-R Indication
> or = 18	**+**
< 18	**-**

What does the Cutoff Score Mean?

For any screening test, the results depend on what cutoff score is chosen. A score that is good at detecting patients at-risk will necessarily include a number of patients that are not really at risk. A score that is good at identifying those at low risk will, in turn, miss a number of patients at risk. A screening measure like the SOAPP-R generally endeavors to minimize the chances of missing high-risk patients. This means that patients who are truly at low risk may still get a score above the cutoff. The table below presents several statistics that describe how effective the SOAPP-R is at different cutoff values. These values suggest that the SOAPP-R is a sensitive test. This confirms that the SOAPP-R is better at identifying who is at high risk than identifying who is at low risk. Clinically, a score of 18 or higher will identify 81% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 18 is .87, which means that most people who have a negative SOAPP-R are likely at low-risk. Finally, the Positive likelihood ratio suggests that a positive SOAPP-R score (at a cutoff of 18) is 2.5 times (2.53 times) as likely to come from someone who is actually at high risk (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). All this implies that by using a cutoff score of 18 will ensure that the provider is least likely to miss someone who is really at high risk. However, one should remember that a low SOAPP-R score suggests the patient is very likely at low-risk, while a high SOAPP-R score will contain a larger percentage of false positives (about 30%); at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more of those who actually do show aberrant behavior.

SOAPP-R Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ration
Score 17 or above	.83	.65	.56	.88	2.38	.26
Score 18 or above	.81	.68	.57	.87	2.53	.29
Score 19 or above	.77	.75	.62	.86	3.03	.31

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

Clinical Opiate Withdrawal Scale (COWS)

Flow-sheet for measuring symptoms for opiate withdrawals over a period of time.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date: _____

Enter scores at time zero, 30min after first dose, 2 h after first dose, etc.

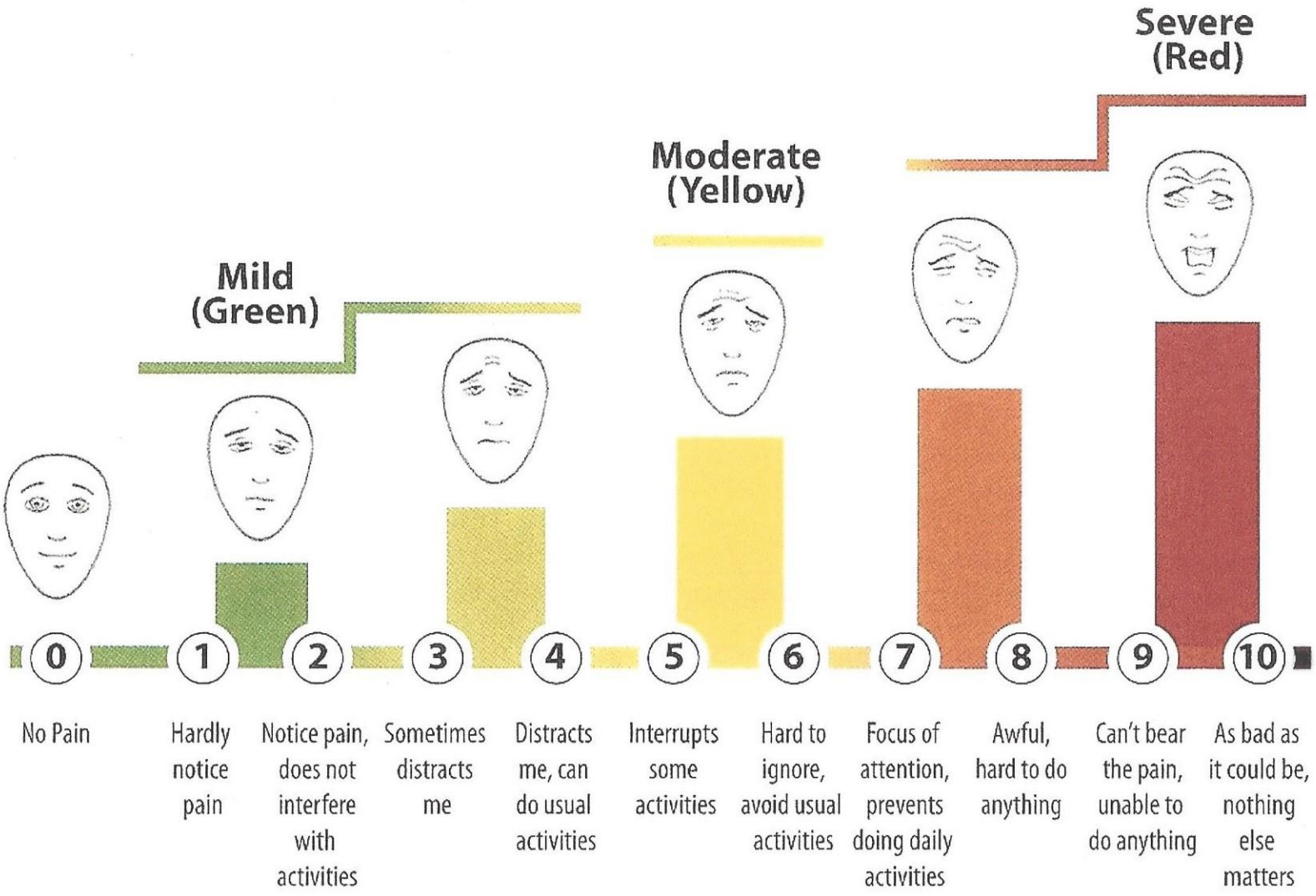
Times: _____ _____ _____ _____

Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness *Observation during assessmen*t 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				

GI Upset: *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting				
Tremor *observation of outstretched hands* 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching				
Yawning *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute				
Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection				
Total scores **with observer's initials**				

Score:
5-12 = mild;
13-24 = moderate;
25-36 = moderately severe;
more than 36 = severe withdrawal

Pain Analog Scale



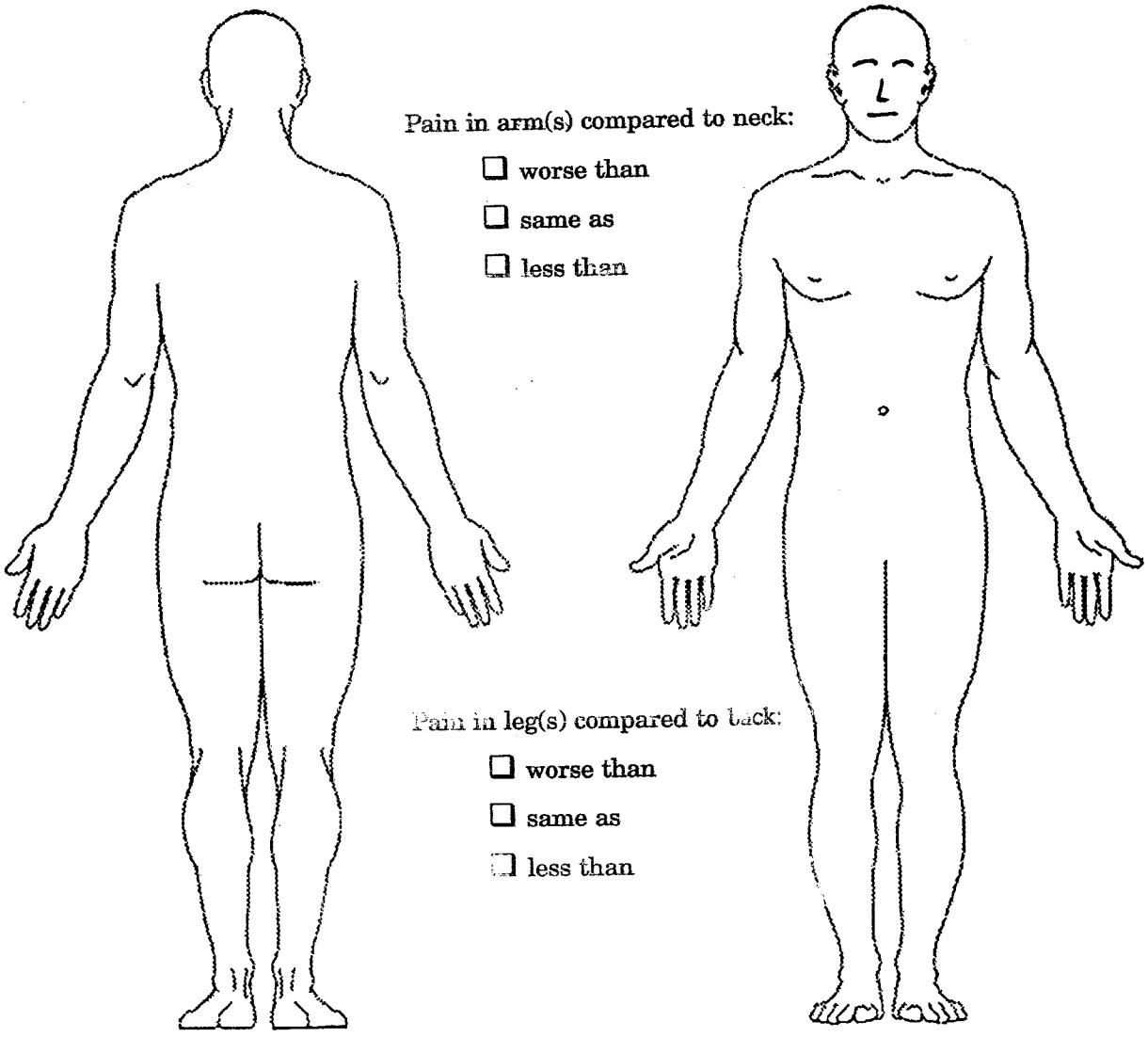
Modified, U.S. Army Pain Management Task Force

Pain Drawing

Name: _____ Date: _____

Mark the areas on your body where you feel the following sensations:

Ache	Numbness	Pins & needles	Burning	Stabbing
^ ^ ^	o o o	• • •	x x x	/ / / /
^ ^ ^	o o o	• • •	x x x	/ / / /



Pain in arm(s) compared to neck:

- ☐ worse than
- ☐ same as
- ☐ less than

Pain in leg(s) compared to back:

- ☐ worse than
- ☐ same as
- ☐ less than

Indicate the severity of your pain by marking an 'X' at the appropriate number:

0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10

Signature : _____

Interpretation of Ransford Pain Drawing

(Ransford et al., Spine 1 (2):127-134, 1976)

There are four parameters of scoring:

1. Unreal Drawings (poor anatomical localization, scores 2 unless indicated, bilateral pain not weighted unless indicated)
    a. total leg pain
    b. lateral whole leg pain (trochanteric area and lateral thigh allowed)
    c. circumferential thigh pain
    d. bilateral anterior tibial pain (unilateral allowed)
    e. circumferential foot pain (scores 1)
    f. bilateral foot pain (scores 1)
    g. use of all four modalities (scores 1)

2. Drawings showing expansion or magnification of pain (may also represent unrelated symptomatology; bilateral pain not weighted)
    a. back pain radiating to iliac crest, groin, or anterior perineum (each scores 1, coccygeal pain allowed)
    b. anterior knee pain (scores 1)
    c. anterior ankle pain (scores 1)
    d. pain drawn outside the outline (scores 1 or 2 depending upon extent)

3. "I Particularly Hurt Here" indicators (each category scores 1, multiple use of each category is not weighted)
    a. add explanatory notes
    b. circle painful areas
    c. draw lines to demonstrate painful areas
    d. use arrows
    e. go to excessive trouble and detail in demonstrating the pain areas

4. "Look How Bad I Am" indicators (additional painful areas in the trunk, head, neck, or upper extremities drawn in. Tendency towards total body pain scores 1 if limited to small areas, otherwise scores 2)

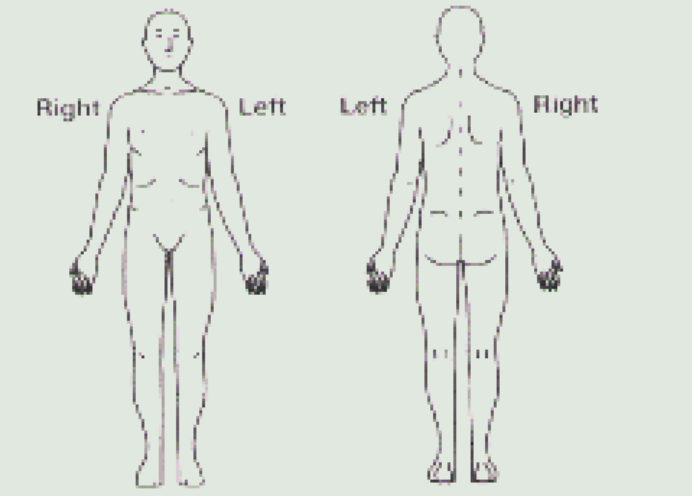
Interpretation: Scores of 3 or more had a 93 % association with a high Hs or Hy score on the MMPI.
Scores of 2 or less had a 79 % association with a low Hs and Hy score on the MMPI.

Brief Pain Inventory (Short Form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the **average**.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain? _____

_____

_____

_____

8. In the last 24 hours, how much relieve have pain treatments or medication provided? Please circle the one percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

G. Enjoyment of Life

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I don't get dressed, I was with difficulty and stay in bed

3. LIFTING

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5. SITTING

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. STANDING

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING

- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELLING

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING

- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

Scoring the Oswestry Disability Index

The Oswestry Disability Index (aka the Oswestry Low Back Pain Disability Questionnaire) is an extremely important tool that researchers and disability evaluators use to measure a patient's permanent functional disability. The test has been around since 1980 and is considered the 'gold standard' of low back pain functional outcome tools.

INSTRUCTIONS:

For each question, there is a possible 5 points; 0 for the first answer, 1 for the second answer, etc. Add up the total for the 10 questions and rate them on the scale at right.

SCORE	DISABILITY LEVEL
0 - 4	No disability
5 - 14	Mild disability
15 - 24	Moderate disability
25 - 34	Severe disability
35 - 50	Completely disabled

No disability
The patient can cope with most living activities. Usually no treatment is indicated apart from advice on lifting, sitting and exercise.

Mild disability
The patient experiences more pain and difficulty with sitting, lifting and standing. Travel and social life are more difficult and they may be disabled from work. Personal care, sexual activity and sleeping are not grossly affected and the patient can usually be managed by conservative means.

Moderate disability
Pain remains the main problem in this group but activities of daily living are affected. These patients require a detailed investigation.

Severe disability
Back pain impinges on all aspects of the patient's life. Positive intervention is required.

Completely disabled
These patients are either bed-bound or are exaggerating their symptoms.

WHY BOTHER WITH AN OUTCOMES MEASURE?
As physical therapy works towards autonomous practice and incorporating evidence-based medicine into it's practice, it is imperative that therapists utilize measuring tools which have been validated through research.

Insurance companies and physicians are very familiar with these instruments and are asking for scores such as Oswestry.

REFERENCES:

- Fairbank JC, Pynsent PB. "**The Oswestry Disability Index.**" *Spine* 2000: 25(22):2940-2952
- Fairbank JCT, Couper J, Davies JB. "**The Oswestry Low Back Pain Questionnaire.**" *Physiotherapy* 1980; 66:271-273

SHORT-FORM McGILL PAIN QUESTIONNAIRE

PATIENT'S NAME_____ DATE

Instructions: Since you have reported that one of your problems is **physical pain**, the purpose of this checklist is for you to give us an idea about what your **physical pain** feels like. Each of the words in the left column describes a quality or characteristic that pain can have. So, for each pain quality in the left column, check the number in that row that tells how much of that specific quality your pain has. Rate every pain quality.

PAIN QUALITY	NONE	MILD	MODERATE	SEVERE
1. Throbbing	(0)_____	(1)_____	(2)_____	(3)_____
2. Shooting	(0)_____	(1)_____	(2)_____	(3)_____
3. Stabbing	(0)_____	(1)_____	(2)_____	(3)_____
4. Sharp	(0)_____	(1)_____	(2)_____	(3)_____
5. Cramping	(0)_____	(1)_____	(2)_____	(3)_____
6. Gnawing	(0)_____	(1)_____	(2)_____	(3)_____
7. Hot-burning	(0)_____	(1)_____	(2)_____	(3)_____
8. Aching	(0)_____	(1)_____	(2)_____	(3)_____
9. Heavy	(0)_____	(1)_____	(2)_____	(3)_____
10. Tender	(0)_____	(1)_____	(2)_____	(3)_____
11. Splitting	(0)_____	(1)_____	(2)_____	(3)_____
12. Tiring-exhausting	(0)_____	(1)_____	(2)_____	(3)_____
13. Sickening	(0)_____	(1)_____	(2)_____	(3)_____
14. Fearful	(0)_____	(1)_____	(2)_____	(3)_____
15. Punishing-cruel	(0)_____	(1)_____	(2)_____	(3)_____

A. PLEASE MAKE AN "X" ON THE LINE BELOW TO SHOW HOW BAD YOUR PAIN IS RIGHT NOW.

NO PAIN |----------| WORST POSSIBLE PAIN

B. PLEASE CHECK THE ONE DESCRIPTOR BELOW THAT BEST DESCRIBES YOUR PRESENT PAIN.

0 NO PAIN _____
1 MILD _____
2 DISCOMFORTING _____
3 DISTRESSING _____
4 HORRIBLE _____
5 EXCRUCIATING _____

C. IS YOUR PAIN ?

(check one word)

_____ Brief
_____ Intermittent
_____ Continuous

S = ___/33 A/E = ___/12

Örebro Musculoskeletal Pain Questionnaire (ÖMPQ)

Linton and Boersma 2003[1]

1. **Name** _____ **Phone** _____ **Date** _____
2. **Date of Injury** _____ **Date of birth** _____
3. **Male** ☐ **Female** ☐
4. **Were you born in the USA?** Yes ☐ No ☐

These questions and statements apply if you have aches or pains, such as back, shoulder or neck pain. Please read and answer questions carefully. Do not take long to answer the questions, however it is important that you answer every question. There is **always** a response for your particular situation.

	2x (max 10)
5. Where do you have pain? Place a tick (✓) for all appropriate sites. ☐ Neck ☐ Shoulder ☐ Arm ☐ Upper Back ☐ Lower Back ☐ Leg ☐ Other (state) _____	
6. How many days of work have you missed because of pain during the past 18 months? Tick (✓) one. ☐ 0 days (1) ☐ 1-2 days (2) ☐ 3-7 days (3) ☐ 8-14 days (4) ☐ 15-30 days (5) ☐ 1 month (6) ☐ 2 months (7) ☐ 3-6 months (8) ☐ 6-12 months (9) ☐ over 1 year (10)	
7. How long have you had your current pain problem? Tick (✓) one. ☐ 0-1 week (1) ☐ 1-2 weeks (2) ☐ 3-4 weeks (3) ☐ 4-5 weeks (4) ☐ 6-8 weeks (5) ☐ 9-11 weeks (6) ☐ 3-6 months (7) ☐ 6-9 months (8) ☐ 9-12 months (9) ☐ over 1 year (10)	
8. Is your work heavy or monotonous? Circle the best alternative. 0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely	
9. How would you rate the pain that you have had during the past week? Circle one. 0 1 2 3 4 5 6 7 8 9 10 No pain Pain as bad as it could be	

10. In the past three months, on average, how bad was your pain on a 0-10 scale? Circle one. 0 1 2 3 4 5 6 7 8 9 10 No pain — Pain as bad as it could be	
11. How often would you say that you have experience pain episodes, on average, during the past three months? Circle one. 0 1 2 3 4 5 6 7 8 9 10 Never — Always	
12. Based on all things you do to cope, or deal with your pain, on an average day, how much are you able to decrease it? Circle the appropriate number. 0 1 2 3 4 5 6 7 8 9 10 Can't decrease it at all — Can decrease it completely	10 - x
13. How tense or anxious have you felt in the past week? Circle one. 0 1 2 3 4 5 6 7 8 9 10 Absolutely clam and relaxed — As tense and anxious as I've ever felt	
14. How much have you been bothered by feeling depressed in the past week? Circle one. 0 1 2 3 4 5 6 7 8 9 10 Not at all — Extremely	
15. In your view, how large is the risk that your current pain may become persistent? Circle one. 0 1 2 3 4 5 6 7 8 9 10 No risk — Very large risk	
16. In your estimation, what are the chances that you will be able to work in six months? Circle one. 0 1 2 3 4 5 6 7 8 9 10 No chance — Very large chance	10 - x
17. If you take into consideration your work routines, management, salary, promotion possibilities and work mates, how satisfied are you with your job? Circle one. 0 1 2 3 4 5 6 7 8 9 10 Not satisfied at all — Completely satisfied	10 - x

Here are some of the things that other people have told us about their pain. For each statement, circle one number from 0 to 10 to say how much physical activities, such as bending, lifting, walking or driving, would affect your pain.

18. Physical activity makes my pain worse.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree — Completely agree

19. An increase in pain is an indication that I should stop what I'm doing until the pain decreases.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree — Completely agree

20. I should not do my normal work with my present pain.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree — Completely agree

Here is a list of five activities. Circle the one number that best describes your current ability to participate in each of these activities.

21. I can do light work for an hour. 10 - x

0 1 2 3 4 5 6 7 8 9 10

Can't do it because of pain problem — Can do it without pain being a problem

22. I can walk for an hour. 10 - x

0 1 2 3 4 5 6 7 8 9 10

Can't do it because of pain problem — Can do it without pain being a problem

23. I can do ordinary household chores. 10 - x

0 1 2 3 4 5 6 7 8 9 10

Can't do it because of pain problem — Can do it without pain being a problem

24. I can do the weekly shopping. 10 - x

0 1 2 3 4 5 6 7 8 9 10

Can't do it because of pain problem — Can do it without pain being a problem

25. I can sleep at night. 10 - x

0 1 2 3 4 5 6 7 8 9 10

Can't do it because of pain problem — Can do it without pain being a problem

Explanatory Notes

The Örebro Musculoskeletal Pain Questionnaire (ÖMPQ) is a 'yellow flag' screening tool that predicts long-term disability and failure to return to work when completed four to 12 weeks following a soft tissue injury[2]. A cut-off score of 105 has been found to predict those who will recover (with 95 per cent accuracy), those who will have no further sick leave in the next six months (with 81 per cent accuracy), and those who will have long-term sick leave (with 67 per cent accuracy)[1].

The ÖMPQ predicted failure to return to work six months after compensable musculoskeletal injury in a NSW population of workers. The injuries in the study group were mixed, and the ÖMPQ was found to be more specific and sensitive for back injuries. In workers with back injuries screened at four to 12 weeks, a cut-off score of 130 correctly predicted 86 per cent of those who failed to return to work[3].

Identification, through the ÖMPQ, of workers at risk of failing to return to work due to personal and environmental factors provides the opportunity for treating practitioners to apply appropriate interventions (including the use of activity programs based on cognitive behavioural strategies) to reduce the risk of long-term disability in injured workers. Evidence indicates that these factors can be changed if they are addressed[4].

Administering the questionnaire

The ÖMPQ is designed to be a self administered tool completed by the worker in a quiet environment without assistance from any other person. A detailed explanation is provided by the person administering the questionnaire:

"Information from this questionnaire helps us understand your problem better, and it especially helps us evaluate the possible long-term consequences your pain may have. It is important that you read each question carefully and answer it as best you can. There are no right or wrong answers. Please answer every question. If you have difficulty, select the answer that best describes your situation".

Where uncertainty or a request for more information is expressed, encouragement is provided to "answer as best you can". The questionnaire item may be read aloud to assist, however the question should not be rephrased. All questions should be answered, as missing values will reduce validity[5].

Scoring instructions

- For question 5, count the number of pain sites and multiply by two – this is the score (maximum score allowable is 10).
- For questions 6 and 7 the score is the number bracketed after the ticked box.
- For questions 8, 9, 10, 11, 13, 14, 15, 18, 19 and 20 the score is the number that has been ticked or circled.
- For questions 12, 16, 17, 21, 22, 23, 24 and 25 the score is 10 minus the number that has been circled.
- Write the score in the shaded area beside each item.
- Add up the scores for questions 5 to 25 – this is the total ÖMPQ score.

1 Linton SJ, Boersma K. Early identification of patients at risk of developing a persistent back problem: the predictive validity of the Örebro Muscuoloskeletal Pain Questionnaire. Clin J Pain 2003;19: 80-86.

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3 Dunstan DA, Covic T, Tyson GA, Lennie, IG (2005) Does the OMPQ predict outcomes following a work related compensable injury? International Journal of Rehabilitation Research 28(4), 369-370.

4 Linton SJ, Ryberg M. A cognitive-behavioral group intervention as prevention for persistent neck and back pain in a non-patient population: a randomized controlled trial. Pain 2001; 83-90.

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Marhold C, Linton SJ, Melin L. A cognitive-behavioral return to work program: effects on pain patients with a history of long-term versus short-term sick leave. Pain 2001; 91:155-163.

5 Linton SJ. Understanding pain for better clinical practice – a psychological perspective. Edinburgh: Elsevier, 2005.

Table S16.2: CRPS Diagnostic Criteria[43]

CRPS-I (RSD) general definition: a painful condition that develops after an initiating noxious event, not limited to the distribution of a single peripheral nerve. The syndrome shows variable progression over time.

In CRPS-II (Causalgia), a specific nerve is involved and pain is within the distribution of the damaged nerve.

To make the clinical diagnosis, the following criteria must be met:

1. Continuing pain, which is disproportionate to any inciting event.

2. Must report at least one symptom in three of the four following categories:
(a) Sensory: Reports of hyperesthesia and /or allodynia
(b) Vasomotor: Reports of temperature asymmetry and/or skin color changes and/or color asymmetry.
(c) Sudomotor/Edema: Reports of edema and/or sweating changes and/or sweating asymmetry.
(d) Motor/Trophic: Reports of decreased range of motion and/or motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin)

3. Must display at least one sign at time of evaluation in two or more of the following categories:
(a) Sensory: Evidence of hyperalgesia and/or allodynia
(b) Vasomotor: Evidence of temperature asymmetry (>1 degree centigrade) and/or skin color changes and/or symmetry
(c) Sudomotor/Edema: Evidence of edema and/or sweating changes and/or sweating asymmetry
(d) Motor/Trophic: Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin)

4. There is no other diagnosis that better explains the signs and symptoms.

Sino-Nasal Outcome Test (SNQT 22) Questionnaire

Name: _____ DOB: _____

Date:

Below you will find a list of symptoms and social/emotional consequences of your nasal disorder. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation.

A. Considering how severe the problem is when you experience it and how frequently it happens, please rate Each item below on how "bad" it is, circling the number that corresponds how you feel using this scale:

	No Problem	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be	Most important items
1. Need to blow nose	0	1	2	3	4	5	[ ]
2. Sneezing	0	1	2	3	4	5	[ ]
3. Runny nose	0	1	2	3	4	5	[ ]
4. Nasal obstruction	0	1	2	3	4	5	[ ]
5. Loss of smell or taste	0	1	2	3	4	5	[ ]
6. Cough	0	1	2	3	4	5	[ ]
7. Post-nasal discharge	0	1	2	3	4	5	[ ]
8. Thick nasal discharge	0	1	2	3	4	5	[ ]
9. Ear fullness	0	1	2	3	4	5	[ ]
10. Dizziness	0	1	2	3	4	5	[ ]
11. Ear pain	0	1	2	3	4	5	[ ]
12. Facial pain/pressure	0	1	2	3	4	5	[ ]
13. Difficulty falling asleep	0	1	2	3	4	5	[ ]
14. Waking up at night	0	1	2	3	4	5	[ ]
15. Lack of a good night's sleep	0	1	2	3	4	5	[ ]
16. Waking up tired	0	1	2	3	4	5	[ ]
17. Fatigue	0	1	2	3	4	5	[ ]
18. Reduced productivity	0	1	2	3	4	5	[ ]
19. Reduced concentration	0	1	2	3	4	5	[ ]
20. Frustrated/restless/irritable	0	1	2	3	4	5	[ ]
21. Sad	0	1	2	3	4	5	[ ]
22. Embarrassed	0	1	2	3	4	5	[ ]
TOTALS (each column):							
GRAND TOTAL SCORE (all columns together):							

B. Please check off the most important items affecting your health in the last column (max of five items)

Kansas City Cardiomyopathy Questionnaire (KCCQ-12)

The following questions refer to your **heart failure** and how it may affect your life. Please read and complete the following questions. There are no right or wrong answers. Please mark the answer that best applies to you.

1. **Heart failure** affects different people in different ways. Some feel shortness of breath while others feel fatigue. Please indicate how much you are limited by **heart failure** (shortness of breath or fatigue) in your ability to do the following activities over the past 2 weeks.

Activity	**Extremely** Limited	**Quite a bit** Limited	**Moderately** Limited	**Slightly** Limited	**Not at all** Limited	Limited for other reasons or did not do the activity
a. Showering/bathing	O	O	O	O	O	O
b. Walking 1 block on level ground	O	O	O	O	O	O
c. Hurrying or jogging (as if to catch a bus)	O	O	O	O	O	O
	1	2	3	4	5	6

2. Over the past 2 weeks, how many times did you have **swelling** in your feet, ankles or legs when you woke up in the morning?

Every morning	3 or more times per week but not every day	1-2 times per week	Less than once a week	Never over the past 2 weeks
O	O	O	O	O
1	2	3	4	5

3. Over the past 2 weeks, on average, how many times has **fatigue** limited your ability to do what you wanted?

All of the time	Several times per day	At least once a day	3 or more times per week but not every day	1-2 times per week	Less than once a week	Never over the past 2 weeks
O	O	O	O	O	O	O
1	2	3	4	5	6	7

4. Over the past 2 weeks, on average, how many times has **shortness of breath** limited your ability to do what you wanted?

All of the time	Several times per day	At least once a day	3 or more times per week but not every day	1-2 times per week	Less than once a week	Never over the past 2 weeks
O	O	O	O	O	O	O
1	2	3	4	5	6	7

5. Over the past 2 weeks, on average, how many times have you been forced to sleep sitting up in a chair or with at least 3 pillows to prop you up because of **shortness of breath**?

Every night	3 or more times per week but not every day	1-2 times per week	Less than once a week	Never over the past 2 weeks
O	O	O	O	O
1	2	3	4	5

6. Over the past 2 weeks, how much has your **heart failure** limited your enjoyment of life?

It has **extremely** limited my enjoyment of life	It has limited my enjoyment of life **quite a bit**	It has **moderately** limited my enjoyment of life	It has **slightly** limited my enjoyment of life	It has **not limited** my enjoyment of life at all
O	O	O	O	O
1	2	3	4	5

7. If you had to spend the rest of your life with your **heart failure** the way it is right now, how would you feel about this?

Not at all satisfied	Mostly dissatisfied	Somewhat satisfied	Mostly satisfied	Completely satisfied
O	O	O	O	O
1	2	3	4	5

8. How much does your **heart failure** affect your lifestyle? Please indicate how your **heart failure** may have limited your participation in the following activities over the past 2 weeks.

Activity	**Severely** Limited	Limited **quite a bit**	**Moderately** limited	**Slightly** limited	**Did not** limit at all	Does not apply or did not do for other reasons
a. Hobbies, recreational activities	O	O	O	O	O	O
b. Working or doing household chores	O	O	O	O	O	O
c. Visiting family or friends out of your home	O	O	O	O	O	O
	1	2	3	4	5	6

Patient Oriented Eczema Measure POEM

Patient Details: _____
_____
_____
_____

Date: _____

Please circle one response for each of the seven questions below about your eczema. Please leave blank any questions you feel unable to answer.

1. Over the last week, on how many days has your skin been itchy because of the eczema?

No days **1-2 days** **3-4 days** **5-6 days** **Every day**

2. Over the last week, on how many nights has your sleep been disturbed because of the eczema?

No days **1-2 days** **3-4 days** **5-6 days** **Every day**

3. Over the last week, on how many days has your skin been bleeding because of the eczema?

No days **1-2 days** **3-4 days** **5-6 days** **Every day**

4. Over the last week, on how many days has your skin been weeping or oozing clear fluid because of the eczema?

No days **1-2 days** **3-4 days** **5-6 days** **Every day**

5. Over the last week, on how many days has your skin been cracked because of the eczema?

No days **1-2 days** **3-4 days** **5-6 days** **Every day**

6. Over the last week, on how many days has your skin been flaking off because of the eczema?

No days **1-2 days** **3-4 days** **5-6 days** **Every day**

7. Over the last week, on how many days has your skin felt dry or rough because of the eczema?

No days **1-2 days** **3-4 days** **5-6 days** **Every day**

Total POEM Score (Maximum 28): _____

POEM
Patient-Oriented Eczema Measure

University of Nottingham
UK | CHINA | MALAYSIA

POEM for self-completion

How is the scoring done?

Each of the seven questions carries equal weight and is scored from 0 to 4 as follows:

No days	= 0
1-2 days	= 1
3-4 days	= 2
5-6 days	= 3
Every day	= 4

Note:

• If one question is left unanswered this is scored 0 and the scores are summed and expressed as usual out of a maximum of 28

• If two or more questions are left unanswered the questionnaire is not scored

• If two or more response options are selected, the response option with the highest score should be recorded

What does a poem score mean?

To help patients and clinicians to understand their POEM scores, the following bandings have been established (see references below):

• 0 to 2	= Clear or almost clear
• 3 to 7	= Mild eczema
• 8 to 16	= Moderate eczema
• 17 to 24	= Severe eczema
• 25 to 28	= Very severe eczema

Do I need permission to use the scale?

The POEM scale is protected by copyright. Commercial users must pay a per patient fee – details are available at https://licensing.micragateway.org/product/poem---patient-orientated-eczema-measure

POEM remains freely available for non-commercial use and can be downloaded from: www.nottingham.ac.uk/dermatology
We do however ask that you register your use of the POEM by e-mailing cebd@nottingham.ac.uk with details of how you would like to use the scale, and which countries the scale will be used in.

References

Charman CR, Venn AJ, Williams HC. The Patient-Oriented Eczema Measure: Development and Initial Validation of a New Tool for Measuring Atopic Eczema Severity From the Patients' Perspective.
Arch Dermatol. 2004;140:1513-1519

Charman CR, Venn AJ, Ravenscroft JC, Williams HC. Translating Patient-Oriented Eczema Measure (POEM) scores into clinical practice by suggesting severity strata derived using anchor-based methods.
Br J Dermatol. Dec 2013; 169(6): 1326–1332.

Patient's Name: _____ **Date:** _____/____/____
month day year

ID#: _____ **Test#:** 1 2 3 4

BOWEL CONTROL SCALE (BWCS)

INSTRUCTIONS

The next set of questions concerns bowel problems that can occur in MS. Many of these questions are very personal, but this is an important topic to cover. If you are marking your own answers, please circle the appropriate response (0, 1, 2,...) based on your bowel function during the past 4 weeks. If you need help in marking your responses, tell the interviewer the number of the best response. Please answer every question. If you are not sure which answer to select, please choose the one answer that comes closest to describing you. The interviewer can explain any words or phrases that you do not understand.

During the past 4 weeks,
how often have you...

		Not at all	Once	Two to four times	More than weekly but not daily	Daily
1.	been constipated?	0	1	2	3	4
2.	lost control of your bowels or had an accident?	0	1	2	3	4
3.	almost lost control of your bowels or almost had an accident ?	0	1	2	3	4
4.	altered your activities because of bowel control problems?	0	1	2	3	4

5. During the past 4 weeks, how much have bowel problems restricted your overall lifestyle? (Please circle one number.)

Not at all										Severely
0	1	2	3	4	5	6	7	8	9	10

Patient's Name: _____ **Date:** _____/____/____
month day year

ID#: _____ **Test#:** 1 2 3 4

BLADDER CONTROL SCALE (BLCS)

INSTRUCTIONS

The next set of questions concerns bladder problems that can occur in MS. Many of these questions are very personal, but this is an important topic to cover. If you are marking your own answers, please circle the appropriate response (0, 1, 2,...) based on your bladder function during the past 4 weeks. If you need help in marking your responses, tell the interviewer the number of the best response. Please answer every question. If you are not sure which answer to select, please choose the one answer that comes closest to describing you. The interviewer can explain any words or phrases that you do not understand.

During the past 4 weeks,
how often have you...

		Not at all	Once	Two to four times	More than weekly but not daily	Daily
1.	lost control of your bladder or had an accident?	0	1	2	3	4
2.	almost lost control of your bladder or had an accident?	0	1	2	3	4
3.	altered your activities because of bladder problems?	0	1	2	3	4

4. During the past 4 weeks, how much have bladder problems restricted your overall lifestyle? (Please circle one number.)

Not at all										Severely
0	1	2	3	4	5	6	7	8	9	10

Gastrointestinal Symptom Rating Scale (GSRS)

Name: _____ Date: ____/____/_____

A rating scale for gastrointestinal symptoms in patients with irritable bowel syndrome and peptic ulcer disease. Circle the number which best represents the current severity of the symptom.

1. Abdominal pains. Representing subjectively experienced bodily discomfort, aches and pains.

The type of pain may be classified according to the patient's description of the appearance and quality of the pain as epigastric, on the basis of typical location, association with acid-related symptoms, and relief of pain by food or antacids; as colicky when occurring in bouts, usually with a high intensity, and located in the lower abdomen; and as dull when continuous, often for several hours, with moderate intensity.

Rate according to intensity, frequency, duration, request for relief, and impact on social performance.

0 No or transient pain
1 Occasional aches and pains interfering with some social activities
2 Prolonged and troublesome aches and pains causing requests for relief and interfering with many social activities
3 Severe or crippling pains with impact on all social activities

2. Heartburn. Representing retrosternal discomfort or burning sensations. Rate according to intensity, frequency, duration, and request for relief.

0 No or transient heartburn
1 Occasional discomfort of short duration
2 Frequent episodes of prolonged discomfort; requests for relief
3 Continuous discomfort with only transient relief by antacids

3. Acid regurgitation. Representing sudden regurgitation of acid gastric content. Rate according to intensity, frequency, and request for relief.

0 No or transient regurgitation
1 Occasional troublesome regurgitation
2 Regurgitation once or twice a day; requests for relief
3 Regurgitation several times a day; only transient and insignificant relief by antacids

4. Sucking sensations in the epigastrium. Representing a sucking sensation in the epigastrium with relief by food or antacids. If food or antacids are not available, the sucking sensations progress to ache, and pains. Rate according to intensity, frequency, duration, and request for relief.

0 No or transient sucking sensation
1 Occasional discomfort of short duration; no requests for food or antacids between meals
2 Frequent episodes of prolonged discomfort, requests for food and antacids between meals
3 Continuous discomfort; frequent requests for food or antacids between meals

5. Nausea and vomiting. Representing nausea which may increase to vomiting. Rate according to intensity, frequency, and duration.

0 No nausea
1 Occasional episodes of short duration
2 Frequent and prolonged nausea; no vomiting
3 Continuous nausea; frequent vomiting

6. Borborygmus. Representing reports of abdominal rumbling. Rate according to intensity, frequency, duration, and impact on social performance

0 No or transient borborygmus
1 Occasional troublesome borborygmus of short duration
2 Frequent and prolonged episodes which can be mastered by moving without impairing social performance
3 Continuous borborygmus severely interfering with social performance

7. Abdominal distension. Representing bloating with abdominal gas. Rate according to intensity, frequency, duration, and impact on social performance.

0 No or transient distension
1 Occasional discomfort of short duration
2 Frequent and prolonged episodes which can be mastered by adjusting the clothing
3 Continuous discomfort seriously interfering with social performance

8. Eructation. Representing reports of belching. Rate according to intensity, frequency, and impact on social performance.

0 No or transient eructation
1 Occasional troublesome eructation
2 Frequent episodes interfering with some social activities
3 Frequent episodes seriously interfering with social performance

9. Increased flatus. Representing reports of excessive wind. Rate according to intensity, frequency, duration, and impact on social performance

0 No increased flatus
1 Occasional discomfort of short duration
2 Frequent and prolonged episodes interfering with some social activities
3 Frequent episodes seriously interfering with social performance

10. Decreased passage of stools. Representing reported reduced defecation. Rate according to frequency. Distinguish from consistency.

0 Once a day
1 Every third day
2 Every fifth day
3 Every seventh day or less frequently

11. Increased passage of stools. Representing reported increased defecation. Rate according to frequency. Distinguish from consistency.

0 Once a day
1 Three times a day
2 Five times a day
3 Seven times a day or more frequently

12. Loose stools. Representing reported loose stools. Rate according to consistency independent of frequency and feelings of incomplete evacuation.

0 Normal consistency
1 Somewhat loose
2 Runny
3 Watery

13. Hard Stools. Representing reported hard stools. Rate according to consistency independent of frequency and feelings of incomplete evacuation.

0 Normal consistency
1 Somewhat hard
2 Hard
3 Hard and fragmented, sometimes in combination with diarrhea

14. Urgent need for defecation. Representing reports of urgent need for defecation, feelings of incomplete control, and inability to control defecation. Rate according to intensity, frequency, and impact on social performance.

0 Normal control
1 Occasional feelings of urgent need for defecation
2 Frequent feelings of urgent need for defecation with sudden need for a toilet interfering with social performance
3 Inability to control defecation

15. Feeling of incomplete evacuation. Representing reports of defecation with straining and a feeling of incomplete evacuation of stools. Rate according to intensity and frequency.

0 Feeling of complete evacuation without straining
1 Defecation somewhat difficult; occasional feelings of incomplete evacuation
2 Defecation definitely difficult; often feelings of incomplete evacuation
3 Defecation extremely difficult; regular feelings of incomplete evacuation

The International Index of Erectile Function (IIEF-5) Questionnaire

The International Index of Erectile Function (IIEF-5) Questionnaire

Over the past 6 months:					
1. How do you rate your **confidence** that you could get and keep an erection?	Very low 1	Low 2	Moderate 3	High 4	Very high 5
2. When you had erections with sexual stimulation, **how often** were your erections hard enough for penetration?	Almost never/never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always/always 5
3. During sexual intercourse, **how often** were you able to maintain your erection after you had penetrated (entered) your partner?	Almost never/never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time)4	Almost always/always 5
4. During sexual intercourse, **how difficult** was it to maintain your erection to completion of intercourse?	Extremely difficult 1	Very difficult 2	Difficult 3	Slightly difficult 4	Not difficult 5
5. When you attempted sexual intercourse, **how often** was it satisfactory for you?	Almost never/never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always/always 5

IIEF-5 scoring:

The IIEF-5 score is the sum of the ordinal responses to the 5 items.

22-25: No erectile dysfunction

17-21: Mild erectile dysfunction

12-16: Mild to moderate erectile dysfunction

8-11: Moderate erectile dysfunction

5-7: Severe erectile dysfunction

INTERNATIONAL INDEX OF ERECTILE FUNCTION

Patient Questionnaire

TODAY'S DATE ☐☐ ☐☐ ☐☐☐☐

NAME .....

DATE OF BIRTH ☐☐ ☐☐ ☐☐☐☐ AGE ☐☐

ADDRESS .....
.....
.....

TELEPHONE .....

These questions ask about the effects that your erection problems have had on your sex life <u>over the last four weeks</u>. Please try to answer the questions as honestly and as clearly as you are able. Your answers will help your doctor to choose the most effective treatment suited to your condition. In answering the questions, the following definitions apply:

- **sexual activity** includes intercourse, caressing, foreplay & masturbation
- **sexual intercourse** is defined as sexual penetration of your partner
- **sexual stimulation** includes situation such as foreplay, erotic pictures etc.
- **ejaculation** is the ejection of semen from the penis (or the feeling of this)
- **orgasm** is the fulfilment or climax following sexual stimulation or intercourse

---

OVER THE PAST 4 WEEKS
CHECK ONE BOX ONLY

☐ **Q1**	**How often were you able to get an erection during sexual activity?**	0 No sexual activity 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ **Q2**	**When you had erections with sexual stimulation, how often were your erections hard enough for penetration?**	0 No sexual activity 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ **Q3**	**When you attempted intercourse, how often were you able to penetrate (enter) your partner?**	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ **Q4**	**During sexual intercourse, <u>how often</u> were you able to maintain your erection after you had penetrated (entered) your partner?**	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ **Q5**	**During sexual intercourse, <u>how difficult</u> was it to maintain your erection to completion of intercourse?**	0 Did not attempt intercourse 1 Extremely difficult 2 Very difficult 3 Difficult 4 Slightly difficult 5 Not difficult

☐ **Q6**	**How many times have you attempted sexual intercourse?**	0 No attempts 1 One to two attempts 2 Three to four attempts 3 Five to six attempts 4 Seven to ten attempts 5 Eleven or more attempts
☐ **Q7**	**When you attempted sexual intercourse, how often was it satisfactory for you?**	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ **Q8**	**How much have you enjoyed sexual intercourse?**	0 No intercourse 1 No enjoyment at all 2 Not very enjoyable 3 Fairly enjoyable 4 Highly enjoyable 5 Very highly enjoyable
☐ **Q9**	**When you had sexual stimulation or intercourse, how often did you ejaculate?**	0 No sexual stimulation or intercourse 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ **Q10**	**When you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax?**	1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ **Q11**	**How often have you felt sexual desire?**	1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ **Q12**	**How would you rate your level of sexual desire?**	1 Very low or none at all 2 Low 3 Moderate 4 High 5 Very high
☐ **Q13**	**How satisfied have you been with your overall sex life?**	1 Very dissatisfied 2 Moderately dissatisfied 3 Equally satisfied & dissatisfied 4 Moderately satisfied 5 Very satisfied
☐ **Q14**	**How satisfied have you been with your sexual relationship with your partner?**	1 Very dissatisfied 2 Moderately dissatisfied 3 Equally satisfied & dissatisfied 4 Moderately satisfied 5 Very satisfied
☐ **Q15**	**How do you rate your confidence that you could get and keep an erection?**	1 Very low 2 Low 3 Moderate 4 High 5 Very high

INTERNATIONAL INDEX OF ERECTILE FUNCTION (IIEF)

Guidelines on Clinical Application of IIEF Patient Questionnaire

Background

The 15-question International Index of Erectile Function (IIEF) Questionnaire is a validated, multi-dimensional, self-administered investigation that has been found useful in the clinical assessment of erectile dysfunction and treatment outcomes in clinical trials. A score of 0-5 is awarded to each of the 15 questions that examine the 4 main domains of male sexual function: erectile function, orgasmic function, sexual desire and intercourse satisfaction.

In a recent study[1],the IIEF Questionnaire was tested in a series of 111 men with sexual dysfunction and 109 age-matched, normal volunteers. The following mean scores were recorded:

FUNCTION DOMAIN	MAX SCORE	CONTROLS	PATIENTS
A. Erectile Function (Q1,2,3,4,5,15)	30	25.8	10.7
B. Orgasmic Function (Q9,10)	10	9.8	5.3
C. Sexual Desire (Q11,12)	10	7.0	6.3
D. Intercourse Satisfaction (Q6,7,8)	15	10.6	5.5
E. Overall Satisfaction (Q13,14)	10	8.6	4.4

Clinical Application

IIEF assessment is limited by the superficial assessment of psychosexual background and the very limited assessment of partner relationship, both important factors in the presentation of male sexual dysfunction. Analysis of the questionnaire should, therefore, be viewed as an adjunct to, rather than a substitute for, a detailed sexual history and examination. The following guide-lines may be applied:

1. Patients with low IEEF scores (<14 out of 30) in Domain A (Erectile Function) may be considered for a trial course of therapy with Sildenafil unless contraindicated. Specialist referral is indicated if this is unsuccessful.

2. Patients demonstrating primary orgasmic or ejaculatory dysfunction (Domain B) should be referred for specialist investigation.

3. Patients with reduced sexual desire (Domain C) require testing of blood levels of androgen and prolactin.

4. Psychosexual counselling should be considered if low scores are recorded in Domains D and E but there is only a moderately lowered score (14 to 25) in Domain A.

Reference

1. Rosen R, Riley A, Wagner G, et al. The International Index of Erectile Function (IIEF): A multidimensional scale for assessment of erectile dysfunction. *Urology*, 1997, **49**: 822-830.

Female Sexual Function Index (FSFI) ©

Subject Identifier _____ Date _____

INSTRUCTIONS: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation and vaginal intercourse.

Sexual intercourse is defined as penile penetration (entry) of the vagina.

Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

CHECK ONLY ONE BOX PER QUESTION.

Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. Over the past 4 weeks, how **often** did you feel sexual desire or interest?

   ☐ Almost always or always
   ☐ Most times (more than half the time)
   ☐ Sometimes (about half the time)
   ☐ A few times (less than half the time)
   ☐ Almost never or never

2. Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?

   ☐ Very high
   ☐ High
   ☐ Moderate
   ☐ Low
   ☐ Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

3. Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?

   - ☐ No sexual activity
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

4. Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity or intercourse?

   - ☐ No sexual activity
   - ☐ Very high
   - ☐ High
   - ☐ Moderate
   - ☐ Low
   - ☐ Very low or none at all

5. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?

   - ☐ No sexual activity
   - ☐ Very high confidence
   - ☐ High confidence
   - ☐ Moderate confidence
   - ☐ Low confidence
   - ☐ Very low or no confidence

6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?

   - ☐ No sexual activity
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

7. Over the past 4 weeks, how **often** did you become lubricated ("wet") during sexual activity or intercourse?

   - ☐ No sexual activity
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

8. Over the past 4 weeks, how **difficult** was it to become lubricated ("wet") during sexual activity or intercourse?

   - ☐ No sexual activity
   - ☐ Extremely difficult or impossible
   - ☐ Very difficult
   - ☐ Difficult
   - ☐ Slightly difficult
   - ☐ Not difficult

9. Over the past 4 weeks, how often did you **maintain** your lubrication ("wetness") until completion of sexual activity or intercourse?

   - ☐ No sexual activity
   - ☐ Almost always or always
   - ☐ Most times (more than half the time)
   - ☐ Sometimes (about half the time)
   - ☐ A few times (less than half the time)
   - ☐ Almost never or never

10. Over the past 4 weeks, how **difficult** was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?

    - ☐ No sexual activity
    - ☐ Extremely difficult or impossible
    - ☐ Very difficult
    - ☐ Difficult
    - ☐ Slightly difficult
    - ☐ Not difficult

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?

- ☐ No sexual activity
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?

- ☐ No sexual activity
- ☐ Extremely difficult or impossible
- ☐ Very difficult
- ☐ Difficult
- ☐ Slightly difficult
- ☐ Not difficult

13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

- ☐ No sexual activity
- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

14. Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?

- ☐ No sexual activity
- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?

- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?

- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ About equally satisfied and dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

17. Over the past 4 weeks, how **often** did you experience discomfort or pain <u>during</u> vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

18. Over the past 4 weeks, how **often** did you experience discomfort or pain <u>following</u> vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Almost always or always
- ☐ Most times (more than half the time)
- ☐ Sometimes (about half the time)
- ☐ A few times (less than half the time)
- ☐ Almost never or never

19. Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?

- ☐ Did not attempt intercourse
- ☐ Very high
- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Very low or none at all

Thank you for completing this questionnaire

Pelvic Pain Questionnaire

Female NIH- Symptom Index (NIH-CPSI)

Name: _____ Date: _____

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas:

		Yes	No
a.	Area between rectum and vagina (perineum)	1	0
b.	Labia	1	0
c.	Clitoris (not related to urination)	1	0
d.	Below your waist, in your pubic or bladder area	1	0
e.	Below your waist, in your rectal area	1	0

2. In the last week, have you experienced:

		Yes	No
a.	Pain or burning during urination	1	0
b.	Pain or discomfort during or after sexual climax	1	0

3. How often have you had pain or discomfort in any of these areas over the last week?

0 Never
1 Rarely
2 Sometimes
3 Often
4 Usually
5 Always

4. Which number best describers your AVERAGE pain or discomfort on the days that you had it, over the last week?

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

0 Not al all
1 Less than 1 time in 5
2 Less than half the time
3 About half the time
4 More than half the time
5 Almost Always or always

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

0 Not al all
1 Less than 1 time in 5
2 Less than half the time
3 About half the time
4 More than half the time
5 Almost Always

Impact of Symptoms

7. How much have your symptoms keep you from doing the kinds of things you would usually do, over the last week?

0 None
1 Only a little
2 Some
3 A lot

8. How much did you think about your symptoms, over the last week?

0 None
1 Only a little
2 Some
3 A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

0 Delighted
1 Pleased
2 Mostly satisfied
3 Mixed (about equally satisfied and dissatisfied)
4 Mostly dissatisfied
5 Unhappy
6 Terrible

Scoring the NIH-Chronic Prostatitis Symptom Index Domains

Pain: Total of items 1a, 1b, 1c, 1d, 1e, 2a, 2b, 3, and 4= ____
Urinary Symptoms: Total of items 5 and 6 = _____
Quality of Life & Impact: Total of items 7, 8, and 9 _____

Adapted from Litwin et al. J Urol. 1999; 162:369-375.

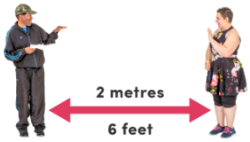
Coronavirus Risk Assessment Form

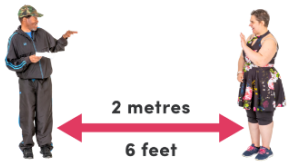
RISK ASSESSMENT FORM			
Name:			
Age:			
Job title:			
COVID RISK FACTORS *			
Ethnicity	Asian or Asian British	4	
	Black	5	
	Mixed	3	
	Other non-white	3	
	White	0	
BMI body mass index (Calculator: https://www.nhs.uk/live-well/healthy-weight/bmi-calculator/)	Under 30	0	
	30 - 34.9	3	
	35 – 39.9	5	
	40 or above	9	
Respiratory disease (affects your lungs)	Mild asthma – no oral steroids in the last year	1	
	Severe asthma – needed oral steroids in the last year	3	
	Chronic respiratory disease (not asthma)	6	
Type 1 Diabetes	Well controlled	7	
	Poorly controlled	12	

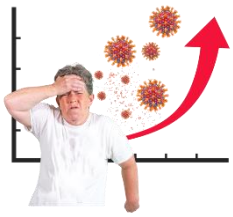
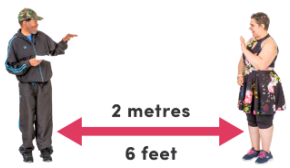
Type 2 Diabetes (and other forms)	Well controlled	4	
	Poorly controlled	8	
Heart disease	Heart failure	8	
	Other heart disease	3	
High blood pressure (based on your age)	20 - 40	11	
	41 - 60	8	
	61 - 74	3	
	75 and over	0	
Neurological diseases (affects your brain)	Cerebrovascular disease (for example stroke or dementia)	8	
	Other chronic neurological disease *	9	
Chronic kidney disease	Mild or moderate	4	
	Severe or end stage	13	
Haematological cancer	Diagnosed less than a year ago	10	
	Diagnosed 1-5 years ago	9	
	Diagnosed more than 5 years ago	5	
Cancer	Diagnosed less than a year ago	5	
	Diagnosed 1-5 years ago	2	
	Diagnosed more than 5 years ago	0	
Other conditions	Liver disease	6	

	Organ transplant **Speak to your transplant team**		
	Spleen dysfunction / splenectomy	3	
	Rheumatoid / lupus / psoriasis	2	
	Other immunosuppressive condition *	6	
	Add all the numbers in the white column together. Write it in the yellow box.		
	If you are female – take 5 away from the number in the yellow box. If you are male the number stays the same. Write the number in the blue box. This is your Covid risk number.		
	Add your actual age to the number in the blue box. This is your Covid age. Write the number in the red box.		

* More detailed information on conditions can be found here: https://alama.org.uk/covid-19-medical-risk-assessment/

RISK LEVELS		
Covid age	**Risk Level**	**Things to think about before going back to work.**
85 or over	**VERY HIGH**	You must be very careful when you leave your home and make careful choices about what you do.
		Work from home if you can.
		If you go to work your employer must make your workplace safe.
		Stay 2 metres away from people at all times.
		Wash your hands often.
		Your manager should refer your Occupational Health for an assessment if you need one (if available). If not, you might want to speak to your doctor or medical specialist

70-85	**HIGH RISK**	You can work.
		Stay 2 metres away from people at all times. If you can't do this you must • make changes to the work you do • or wear personal protective equipment.
		If you do clinical work, care work or work closely with other people you must wear a face covering, use screen or wear PPE.
		If you're a key worker, you may be asked to accept a higher risk where there's a good reason. After discussion you may agree to accept this risk.

50-70	**MODERATE RISK**	You are less likely to be very ill if you get coronavirus. You can work.
		If you do clinical work, care work or work closely with others you should wearing a face covering, use screens or wear PPE.
		There may be a higher risk of infection if it is hard to reduce any risks because of the type of work you do. This includes work where physical control or restraint is required.
49 or less	**LOW RISK**	You are not likely to be very ill if you get coronavirus.
		It is still very important to follow all the guidance to prevent you getting coronavirus.

PREGNANCY	
	You or your baby are not at a higher risk from coronavirus unless you have a health condition.
	Keep any risk as low as you can by staying 2 metres apart from other people Wash your hands often.
	You should have some choice about being at work or change the work you do. Get more information from the Royal College of Obstetricians and Gynaecologists: https://www.rcog.org.uk/coronavirus-pregnancy
	Try not to work with patients or clients or work closely with other people.

Risk group agreed:	Very High	☐
	High	☐
	Moderate	☐
	Low	☐

What we will do and how we will keep me safe:

Name of manager: 	Signature: 
Name of staff member: 	Signature: 

Post-Covid Cough Evaluation

Please, read each question carefully to assess your condition and give the response that best applies to you. Circle the best answer:	None 1	Seldom 2	Some times 3	Often 4	All the time 5
How frequently did you cough during the day?	1	2	3	4	5
Has your cough disturbed your sleep?	1	2	3	4	5
Did you have intense cough?	1	2	3	4	5
Has your cough interfered with your daily life?	1	2	3	4	5
Has your cough made you feel anxious or depressed?	1	2	3	4	5
				Total score	

Adapted from a study that appeared in BMC Pulmonary Medicine.

The Five P's approach for health care providers obtaining sexual histories: partners, practices, protection from sexually transmitted infections, past history of sexually transmitted infections, and pregnancy intention

1.
    1. **Partners**
    2. "Are you currently having sex of any kind?"
    3. "What is the gender(s) of your partner(s)?"

    2. **Practices**

    - "To understand any risks for sexually transmitted infections (STIs), I need to ask more specific questions about the kind of sex you have had recently."
    - "What kind of sexual contact do you have or have you had?"
        - "Do you have vaginal sex, meaning 'penis in vagina' sex?"
        - "Do you have anal sex, meaning 'penis in rectum/anus' sex?"
        - "Do you have oral sex, meaning 'mouth on penis/vagina'?"

    3. **Protection from STIs**

    - "Do you and your partner(s) discuss prevention of STIs and human immunodeficiency virus (HIV)?"
    - "Do you and your partner(s) discuss getting tested?"
    - For condoms:
        - "What protection methods do you use? In what situations do you use condoms?"

    4. **Past history of STIs**

    - "Have you ever been tested for STIs and HIV?"
    - "Have you ever been diagnosed with an STI in the past?"
    - "Have any of your partners had an STI?"

Additional questions for identifying HIV and viral hepatitis risk:

- "Have you or any of your partner(s) ever injected drugs?"
- "Is there anything about your sexual health that you have questions about?"

5. **Pregnancy intention**

- “Do you think you would like to have (more) children in the future?”
- “How important is it to you to prevent pregnancy (until then)?”
- “Are you or your partner using contraception or practicing any form of birth control?”
- “Would you like to talk about ways to prevent pregnancy?”

PATIENT LABEL AREA

STD RISK ASSESSMENT QUESTIONNAIRE

All information is CONFIDENTIAL and will help identify the services you need.

Today's date:_____

Have you been seen in this STD clinic before? ☐ Yes ☐ No When? _____

1. What is the reason for your visit? *(check all that apply)*
   - ☐ Have symptoms
   - ☐ No symptoms –STD testing/screening only
   - ☐ Referred by another doctor or clinic
   - ☐ Think you could be at risk for an STD/HIV
   - ☐ Someone told you to come today
   - ☐ Other: _____
2. If you have symptoms, please check all that apply:
   ☐ Bleeding ☐ Pain ☐ Rash ☐ Discharge ☐ Sores/Blisters
   ☐ Warts ☐ Itch ☐ Problems with urination ☐ Other: _____
3. Have you had sex in the last 6 months? ..... ☐ Yes ☐ No
   With how many people? 1 2 3 4 5 6 7 8 9 10 more than 10
4. How many people have you had sex with in your lifetime?
   0 1 2 3 4 5 10 15 25 30 50 75 More than 100
5. When with new or non-steady partners, do you use a condom or barrier?
   ☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never
6. Have you had sex with: ☐ A man ☐ A woman ☐ Both ☐ Other _____
7. Check all that apply ☐ Oral sex ☐ Vaginal sex
   ☐ Anal sex: ☐ Top (Insertive) ☐ Bottom (Receptive) ☐ Both
8. Have you ever experienced domestic violence? ..... ☐ Yes ☐ No
9. Please list any medication(s) you are currently taking: _____
10. Please list any allergies to medication(s)?: _____
11. Have you ever exchanged drugs or money for sex? ..... ☐ Yes ☐ No
12. Have you had sex with someone you know injects drugs? ..... ☐ Yes ☐ No
13. Have you ever used a needle to inject drugs? ..... ☐ Yes ☐ No
14. Have you had sex with someone you know has HIV/AIDS? ..... ☐ Yes ☐ No
15. Have you used meth, speed, crank, crystal, cocaine, or crack in the last year? ..... ☐ Yes ☐ No
16. Do you smoke cigarettes? ..... ☐ Yes ☐ No
17. Have you ever been in jail or prison? ..... ☐ Yes ☐ No
18. Do you have any tattoos? ..... ☐ Yes ☐ No
19. Have you had the Hepatitis B vaccine? ..... ☐ Yes ☐ No
20. How many HIV/AIDS tests have you had before today? _____
21. Have you ever been diagnosed with an STD? *(check all that apply below and indicate when)*
    - ☐ Chlamydia _____
    - ☐ Gonorrhea _____
    - ☐ Genital Warts _____
    - ☐ Herpes _____
    - ☐ NGU/NSU _____
    - ☐ Syphilis _____
    - ☐ Trichomonas (trich) _____
    - ☐ HIV _____
    - ☐ Other: _____
    - ☐ **Never** been diagnosed with an STD
22. Do you or your female sex partners use birth control? ..... ☐ Yes ☐ No ☐ Not sure
23. If so, what birth control method(s) are used: _____ ☐ Not sure
24. Would you like more information on birth control methods? ..... ☐ Yes ☐ No

STI Education	☐ Yes ☐ No	Adolescent counseling done per protocol	☐ Yes ☐ No
MOC Education	☐ Yes ☐ No	E. C. provided/discussed	☐ Yes ☐ No
Risk Reduction Education	☐ Yes ☐ No	Condoms Dispensed	☐ Yes ☐ No
M:\Maria Docs\Forms in Progress\STDRisk Ass-Eng-Jun2010.doc mdr		TSE	☐ Yes ☐ No

HIV Risk Assessment: Page 1

Client's name/ID number/chart number _____

Columbia University HIV Mental Health Training Project, 06/98

I'd like to ask you some questions about some of your intimate behaviors over the past 6 months. So since today is (date)_____, think about what's been happening in your life back to (date 6 months ago) _____. Please remember that everything you tell me will be kept confidential.

I'm going to start by asking you some questions about your sexual experiences if that's ok with you. If you find that any of these questions make you feel uncomfortable, or if there's anything that's unclear, please tell me. First, I'd like to talk briefly about the words people use to describe their bodies and their sexual behaviors.

Oral sex is when a person puts their mouth on another person's *penis* or *vagina*.
Is there another word you use for oral sex? _____ penis? _____ vagina? _____
Vaginal sex is when a person puts his *penis* in another person's *vagina*.
Is there another word you use for vaginal sex? _____
Anal sex is when a person puts his *penis* in another person's *anus* or *rectum.*
Is there another word you use for anal sex? _____ anus or rectum? _____

So, if you remember all the types of sex you've had since (date 6 months ago) _____, how many times since then did you:

FOR MEN:	**FOR WOMEN:**
Have *receptive oral sex* with a man, that is put your mouth on his *penis*. _____	Have *oral sex* with a man, that is put your mouth on his *penis*. _____
How many different men did you have *receptive oral sex* with. _____	How many different men did you have *oral sex* with. _____
How many of the times that you had *receptive oral sex* with a man did you use a condom or other barrier. never ( ) sometimes ( ) mostly ( ) always ( )	How many of the times that you had *oral sex* with a man did you use a condom or other barrier. never ( ) sometimes ( ) mostly ( ) always ( )
Have *insertive oral sex* with a man, that is put your *penis* in his mouth. _____	**SKIP TO BELOW**
How many different men did you have *insertive oral sex* with. _____	**SKIP TO BELOW**
How many of the times that you had *insertive oral sex* with a man did you use a condom or other barrier. never ( ) sometimes ( ) mostly ( ) always ( )	**SKIP TO BELOW**
Have *oral sex* with a woman, that is put your mouth on her *vagina*. _____	Have *oral sex* with a woman, that is put your mouth on her *vagina*. _____
How many different women did you have *oral sex* with. _____	How many different women did you have *oral sex* with. _____
How many of the times that you had *oral sex* with a woman did you use a dental dam or other barrier. never ( ) sometimes ( ) mostly ( ) always ( )	How many of the times that you had *oral sex* with a woman did you use a dental dam or other barrier. never ( ) sometimes ( ) mostly ( ) always ( )
Have *vaginal sex* with a woman, that is put your *penis* in her *vagina*. _____	Have *vaginal sex* with a man, that is he put his *penis* in your *vagina*. _____
How many different women did you have *vaginal sex* with. _____	How many different men did you have *vaginal sex* with. _____
How many of the times you had *vaginal sex* did you use a condom: never ( ) sometimes ( ) mostly ( ) always ( )	How many of the times you had *vaginal sex* did you use a condom: never ( ) sometimes ( ) mostly ( ) always ( )
Have *receptive anal sex* with a man, that is he put his *penis* in your anus or rectum. _____	Have *receptive anal sex* with a man, that is he put his *penis* in your anus or rectum. _____

How many different sexual partners did you have *receptive anal sex* with._____	How many different sexual partners did you have *receptive anal sex* with._____
How many of the times you had *receptive anal sex* did you use a condom:never	How many of the times you had *receptive anal sex* did you use a condom: neve
Have *insertive anal sex* with a man, that is you put your *penis* in his anus or rectum. _____	**SKIP TO BELOW**
How many different men did you have *insertive anal sex* with. _____	**SKIP TO BELOW**
How many of the times you had *insertive anal sex* with a man did you use a condom: never ( ) sometimes ( ) mostly ( ) always ( )	**SKIP TO BELOW**
Have *anal sex* with a woman, that is put your *penis* in her anus or rectum._____	**SKIP TO BELOW**
How many different women did you have *anal sex* with. _____	**SKIP TO BELOW**
How many of the times you had *anal sex* with a woman did you use a condom: never ( ) sometimes ( ) mostly ( ) always ( )	**SKIP TO BELOW**
Overall, in the past 6 months how many times did you have sex after drinking alcohol or using other drugs: never ( ) sometimes ( ) mostly ( ) always ( )	Overall, in the past 6 months how many times did you have sex after drinking alcohol or using other drugs: never ( ) sometimes ( ) mostly ( ) always ( )
Overall, in the past 6 months how many times did you trade sex: For money _____ For drugs _____ For anything else (for example, cigarettes, a place to stay) _____	Overall, in the past 6 months how many times did you trade sex: For money _____ For drugs _____ For anything else (for example, cigarettes, a place to stay) _____
Overall, in the past 6 months how many of your sexual partners were: bisexual men _____ bisexual women _____ someone who injects drugs _____ someone who trades sex for drugs _____ someone who sells sex _____ someone with HIV infection or AIDS _____ someone you've known less than a week _____ someone you met at the clinic _____	Overall, in the past 6 months how many of your sexual partners were: bisexual men _____ bisexual women _____ someone who inject drugs _____ someone who trades sex for drugs _____ someone who sells sex _____ someone with HIV infection or AIDS _____ someone you've known less than a week _____ someone you met at the clinic _____
When was the last time someone forced you to have sexual contact: within the last week ( ) within the last month ( ) within the last 6 months ( ) within the last year ( ) before a year ago ( ) never ( )	When was the last time someone forced you to have sexual contact: within the last week ( ) within the last month ( ) within the last 6 months ( ) within the last year ( ) before a year ago ( ) never ( )

In the past 6 months, did you have any outbreaks of:

gonorrhea: yes ( ) no ( ) syphilis: yes ( ) no ( ) genital herpes: yes ( ) no ( )
genital warts: yes ( ) no ( ) chlamydia: yes ( ) no ( )
any other sexually transmitted infection, sometimes called venereal disease yes ( ) no ( )
name of infection _____
any burning, itching, sores, swelling, pus, blood, or discomfort in your genitals yes ( ) no ( )
which of these _____

Did you get medical treatment? yes ( ) no ( )

HIV Risk Assessment: Page 2

Columbia University HIV Mental Health Training Project, 06/98

Now I'm going to ask you some questions about your alcohol and other drug use during the past six months. So think about what's been happening in your life back to (date 6 months ago) _____. Please remember that everything you tell me will be confidential.

I'm going to start by asking you some questions about your experiences with alcohol and other drugs if that's ok with you. If you find that any of these questions make you feel uncomfortable, please tell me. Also, there are many different words that people use for drugs and for how drugs are used, so if I use any words that are unclear, please let me know, and if there are any words that you use that are unfamiliar to me, I'll let you know.

Since (date 6 months ago) _____, how often did you:

Drink alcohol	every day ( ) about once a week ( ) about once a month ( ) about once in 6 months ( ) never ( )
Use marijuana/hashish	every day ( ) about once a week ( ) about once a month ( ) about once in 6 months ( ) never ( )
Smoke crack	every day ( ) about once a week ( ) about once a month ( ) about once in 6 months ( ) never ( )
Snort or huff any substance (such as cocaine or heroin or glue or gas)	every day ( ) about once a week ( ) about once a month ( ) about once in 6 months ( ) never ( )
Inject any drug	every day ( ) about once a week ( ) about once a month ( ) about once in 6 months ( ) never ( ) **IF NEVER, SKIP NEXT 3**
Use needles, syringes, works, cookers, wash-water, or any other injection equipment after someone else had used them	every day ( ) about once a week ( ) about once a month ( ) about once in 6 months ( ) never ( )
Clean with bleach all the injection equipment you used after someone else had used it	every day ( ) about once a week ( ) about once a month ( ) about once in 6 months ( ) never ( )
Inject with someone who was:	a stranger ( ) someone you know somewhat but not well ( ) a family member ( ) a sexual partner ( ) a running buddy ( ) any other person you know well ( )

Now I want to ask you about your previous contact with agencies where health care may be provided.
Since (date 6 months ago) _____, did you spend time:

in a medical hospital yes ( ) no ( )
in a psychiatric unit or hospital yes ( ) no ( )
in a community mental health clinic yes ( ) no ( )
in a methadone maintenance clinic yes ( ) no ( )
in a jail or prison yes ( ) no ( )

When was your last HIV test?
within the last 6 months ( )
within the last year ( )
more than a year ago ( )
never ( ) **IF NEVER, GO TO NEXT PAGE**

Did you receive pre-test counseling yes ( ) no ( )

Did you receive post-test counseling yes ( ) no ( )

Did you feel that the HIV test counseling you received prepared you for your test result? yes ( ) no ( )
if no, probe for what might have been done better and record response:

Are you worried about HIV/AIDS? yes ( ) no ( )

probe for AIDS-related concerns, record them and how you addressed them:

Do you know how it's passed from person to person? yes ( ) no ( )

probe for transmission knowledge, record misperceptions and how you addressed them:

Do you know how to prevent yourself from
getting the virus or passing it to someone else? yes ( ) no ( )

probe for prevention knowledge, record misperceptions and how you addressed them:

Would you like to learn more about:
sex education ( )
contraception ( )
condom use ( )
AIDS prevention ( )
HIV testing ( )
medical signs of HIV and AIDS and how they're treated ( )

Needs referral:
sex education ( )
contraception ( )
condom use ( )
AIDS prevention ( )
HIV testing ( )
medical ( )

Record any difficulties with the interview:

Record your concerns that could not be addressed in the interview:

Record any other comments about the interview:

YaleNewHavenHealth

Monkeypox Post-Exposure Staff Evaluation and Management

Applies to all workplace monkeypox exposures to YNHHS staff

STEP 1: **Determine HCW PPE and Contact Setting with Monkeypox Source**	**STEP 2:** **Determine Risk level**
HCW PPE and Type of Contact with Monkeypox Source	**Exposure Level**
Meets one or more of the following: ☐ Unprotected contact between a HCW skin or mucous membranes and the Source Patient's skin, lesions, or bodily fluids (e.g., inadvertent splashes of patient saliva to the eyes or oral cavity of a person, ungloved contact with patient), or contaminated materials (e.g., linens, clothing) ☐ Being in the patient's room during any procedure that may create aerosols oral secretions, skin lesions, or re-suspension of dried exudates (e.g., shaking of soiled linens) **while NOT wearing both an N95 or equivalent respirator AND eye protection**	**HIGH RISK**
Meets one or more of the following: ☐ Being within 6 feet of an unmasked patient for **greater than or equal to 3 hours** while NOT wearing a facemask or N95/equivalent respirator ☐ Activities resulting in contact between sleeves and other parts of an individual's clothing and the patient's skin lesions or bodily fluids, or their soiled linens or dressings (e.g., turning, bathing, or assisting with transfer) while wearing gloves but not wearing a gown.	**INTERMEDIATE RISK**
Meets one or more of the following: ☐ Entered the patient's room one or more times without eye protection REGARDLESS of duration** ☐ Wore gown, gloves, eye protection, and at minimum, a facemask during one or more entries in the patient care area or room, but not an N95 or equivalent respirator** ☐ Was within 6 feet of an unmasked patient for less than 3 hours while NOT wearing a facemask ***If an aerosol-generating procedure was performed in the room while the employee was not wearing an N95 or equivalent respirator, refer to the "High Risk" criteria*	**LOW RISK** **---** **UNCERTAIN RISK**

Potential Communicable Disease Exposure Investigation

Disease:		**DN and Location:**	
Date of Investigation:		**Dates of Exposure:**	
Index Patient/Staff Name:		**Index Patient MRN/employee #:**	
Patient Admit Date:		**Patient Discharge Date:**	
Describe Event:			
Actions Taken:			
Outcomes/Results:			
# Patients exposed:	**# Patients with F/U:**	**# Patients treated/pos test:**	
# HCW exposed:	**# HCW with F/U:**	**# HCW treated/pos test:**	
IP Contact Name and phone #:			
Occ Health Contact Name and phone #:			
Dated Reported to ICC:			

PEP, PEP++ and PrEP

- **PEP** – Post exposure prophylactic vaccination after an identified high-risk exposure, ideally within 4 days (up to 14)
- **PEP++** (Expanded PEP) presumptive vaccination of individuals more likely to have recently been exposed.
  - Does not require documented exposure.
  - *Current monkeypox outbreak response strategy.*

Vaccine allocation from Strategic National Stockpile to states: https://aspr.hhs.gov/SNS/Pages/JYNNEOS-Distribution.aspx

- ~1 million doses allocated to states, 617,693 requested and shipped as of 8/8/22
- 6.9 million doses anticipated in US supply by mid-2023

- **PrEP** - preexposure prophylaxis for individuals at high risk
  - Primary use of occupational vaccination
  - Laboratorians handling orthopoxvirus, or samples known/suspected to contain orthopoxvirus
  - Special pathogen healthcare teams – theoretical smallpox risk outweighed by monkeypox outbreak

Separate allocation and distribution process via CDC drug service.

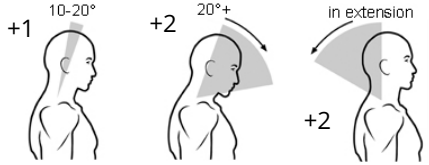
ERGONOMICS PLUS

REBA Employee Assessment Worksheet

Task Name: Date:

A. Neck, Trunk and Leg Analysis

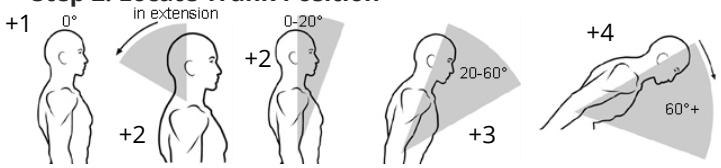
Step 1: Locate Neck Position



Neck Score

Step 1a: Adjust...
If neck is twisted: +1
If neck is side bending: +1

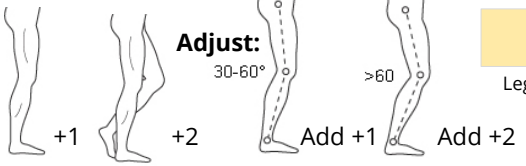
Step 2: Locate Trunk Position



Trunk Score

Step 2a: Adjust...
If trunk is twisted: +1
If trunk is side bending: +1

Step 3: Legs



Leg Score

Step 4: Look-up Posture Score in Table A

Using values from steps 1-3 above,
Locate score in Table A

Posture Score A

+

Step 5: Add Force/Load Score

If load < 11 lbs. : +0
If load 11 to 22 lbs. : +1
If load > 22 lbs.: +2
Adjust: If shock or rapid build up of force: add +1

Force / Load Score

=

Step 6: Score A, Find Row in Table C

Add values from steps 4 & 5 to obtain Score A.
Find Row in **Table C**.

Score A

Scoring
1 = Negligible Risk
2-3 = Low Risk. Change may be needed.
4-7 = Medium Risk. Further Investigate. Change Soon.
8-10 = High Risk. Investigate and Implement Change
11+ = Very High Risk. Implement Change

Scores

Table A		Neck											
		1				2				3			
	Legs	1	2	3	4	1	2	3	4	1	2	3	4
Trunk Posture Score	1	1	2	3	4	1	2	3	4	3	3	5	6
	2	2	3	4	5	3	4	5	6	4	5	6	7
	3	2	4	5	6	4	5	6	7	5	6	7	8
	4	3	5	6	7	5	6	7	8	6	7	8	9
	5	4	6	7	8	6	7	8	9	7	8	9	9

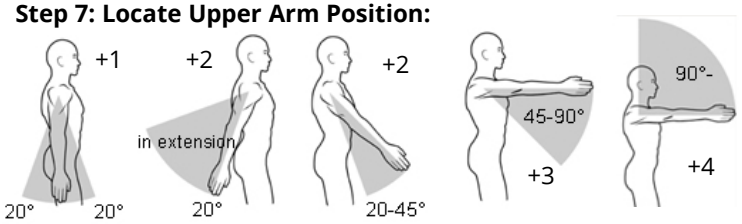
Table B		Lower Arm					
		1			2		
	Wrist	1	2	3	1	2	3
Upper Arm Score	1	1	2	2	1	2	3
	2	1	2	3	2	3	4
	3	3	4	5	4	5	5
	4	4	5	5	5	6	7
	5	6	7	8	7	8	8
	6	7	8	8	8	9	9

Score A	Table C											
	Score B											
	1	2	3	4	5	6	7	8	9	10	11	12
1	1	1	1	2	3	3	4	5	6	7	7	7
2	1	2	2	3	4	4	5	6	6	7	7	8
3	2	3	3	3	4	5	6	7	7	8	8	8
4	3	4	4	4	5	6	7	8	8	9	9	9
5	4	4	4	5	6	7	8	8	9	9	9	9
6	6	6	6	7	8	8	9	9	10	10	10	10
7	7	7	7	8	9	9	9	10	10	11	11	11
8	8	8	8	9	10	10	10	10	10	11	11	11
9	9	9	9	10	10	10	11	11	11	12	12	12
10	10	10	10	11	11	11	11	12	12	12	12	12
11	11	11	11	11	12	12	12	12	12	12	12	12
12	12	12	12	12	12	12	12	12	12	12	12	12

Table C Score + Activity Score = REBA Score

B. Arm and Wrist Analysis

Step 7: Locate Upper Arm Position:



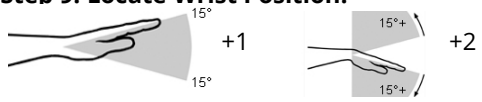
Step 7a: Adjust...
If shoulder is raised: +1
If upper arm is abducted: +1
If arm is supported or person is leaning: -1

Upper Arm Score

Step 8: Locate Lower Arm Position:

Lower Arm Score

Step 9: Locate Wrist Position:



Wrist Score

Step 9a: Adjust...
If wrist is bent from midline or twisted : Add +1

Step 10: Look-up Posture Score in Table B

Using values from steps 7-9 above, locate score in Table B

Posture Score B

+

Step 11: Add Coupling Score

Well fitting Handle and mid rang power grip, ***good: +0***
Acceptable but not ideal hand hold or coupling acceptable with another body part, ***fair: +1***
Hand hold not acceptable but possible, ***poor: +2***
No handles, awkward, unsafe with any body part, ***Unacceptable: +3***

Coupling Score

=

Step 12: Score B, Find Column in Table C

Add values from steps 10 &11 to obtain Score B. Find column in **Table C** and match with Score A in row from step 6 to obtain Table C Score.

Score B

Step 13: Activity Score

+1 1 or more body parts are held for longer than 1 minute (static)
+1 Repeated small range actions (more than 4x per minute)
+1 Action causes rapid large range changes in postures or unstable base

Original Worksheet Developed by Dr. Alan Hedge. Based on Technical note: Rapid Entire Body Assessment (REBA), Hignett, McAtamney, Applied Ergonomics 31 (2000) 201-205

CUErgo

Cornell University Ergonomics Web

REBA Worksheet

The Rapid Entire Body Assessment (REBA) method was developed by Dr. Sue Hignett and Dr. Lynn McAtamney , ergonomists from University of Nottingham in England (Dr. McAtamney is now at Telstra, Australia) . REBA is a postural targeting method for estimating the risks of work-related entire body disorders. A REBA assessment gives a quick and systematic assessment of the complete body postural risks to a worker. The analysis can be conducted before and after an intervention to demonstrate that the intervention has worked to lower the risk of injury.

A full description of the REBA method is contained in the original journal article:
Hignett, S. and McAtamney, L. (2000) Rapid Entire Body Assessment: REBA, Applied Ergonomics, 31, 201-5.

The following files are downloadable '.pdf' files, and they can be viewed and printed in Adobe Acrobat/Acrobat Reader.

- Click here to download the Rapid Entire Body Assessment (REBA) score worksheet (28K).
- Click here to download the Rapid Entire Body Assessment (REBA) slideshow (140K)
- Click here to download the Rapid Entire Body Assessment (REBA) XL worksheet
  (Created by Michael Rusin, ActewAGL and TransACT, Australia)
- REBA Worksheet (rbarker@ergosmart.com)

Computerized REBA assessments:

- ErgoIntelligence (NexGen)

Neck Disability Index

Instructions

This questionnaire has been designed to give your health practitioner information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realise you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal care (washing, dressing)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 – Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently
- ☐ I have headaches almost all the time.

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8 – Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I cannot do any recreation activities at all.

Neck Disability Index

Source: Vernon H, Mior S. The Neck Disability Index: a study of reliability and validity. *J Manipulative Physiol Ther.* 1991 Sep;14(7):409-15.

Neck disorders are a significant source of pain and activity limitation in workers and those involved in motor vehicle collisions. The Neck Disability Index (NDI) [1] is designed to measure neck-specific disability. The questionnaire has 10 items concerning pain and activities of daily living including personal care, lifting, reading, headaches, concentration, work status, driving, sleeping and recreation. The measure is designed to be given to the patient to complete, and can provide useful information for management and prognosis of those with neck pain.

Scoring and interpretation

Each item is scored out of five (with the no disability response given a score of 0) giving a total score for the questionnaire out of 50. Higher scores represent greater disability. The result can be expressed as a percentage (score out of 100) by doubling the total score.

The ‘Clinical guidelines for best practice management of acute and chronic whiplash-associated disorders’ [2] indicate that about 40% of patients with whiplash recover in less than four weeks, and that by six weeks about 50% have recovered. The guidelines recommend the use of the NDI to screen for risk factors and evaluate treatment effectiveness. An NDI score of >40/100 at initial assessment (first consultation following an injury) is associated with ongoing pain and disability after whiplash. This can alert a practitioner to the potential need for more regular review, or early referral to a specialised health provider such as a physiotherapist, chiropractor or psychologist. The guidelines indicate that ‘recovery’ is represented by an NDI score of less than 8/100, at which time treatment should be ceased.

References

1. Vernon H, Mior S. The Neck Disability Index: a study of reliability and validity. *J Manipulative Physiol Ther* 1991 Sep;14(7):409-15.

2. TRACsa Trauma Injury and Recovery. Clinical guidelines for best practice management of acute and chronic whiplash-associated disorders. Canberra: National Health and Medical Research Council; 2008.

OXFORD SHOULDER INSTABILITY SCORE

RIGHT ☐

LEFT ☐

Problems with your shoulder

✓ tick **one** box for each question

1 During the last **6 months** …

how many times has your shoulder slipped out of joint (or dislocated)?

Not at all in **6 months**	1 or 2 times in **6 months**	1 or 2 times **per month**	1 or 2 times **per week**	More often than 1 or 2 times/week
☐	☐	☐	☐	☐

2 During the last **3 months** …

have you had any trouble (or worry) with putting on a T-shirt or pullover *because of your shoulder*?

No trouble/ no worries	Slight trouble or worry	Moderate trouble or worry	Extreme difficulty	Impossible to do
☐	☐	☐	☐	☐

3 During the last **3 months** …

how would you describe the worst pain you have had *from your shoulder*?

None	Mild ache	Moderate	Severe	Unbearable
☐	☐	☐	☐	☐

4 During the last **3 months** …

how much has *the problem with your shoulder* interfered with your usual work? (including school or college work, or housework)

Not at all	A little bit	Moderately	Greatly	Totally
☐	☐	☐	☐	☐

5 During the last **3 months** …

have you avoided any activities due to *worry about your shoulder* – feared that it might slip out of joint?

No, not at all	Very occasionally	Some days	Most days or more than one activity	Every day or many activities
☐	☐	☐	☐	☐

6 During the last **3 months** …

has *the problem with your shoulder* prevented you from doing things that are important to you?

No, not at all	Very occasionally	Some days	Most days or more than one activity	Every day or many activities
☐	☐	☐	☐	☐

Oxford Instability Shoulder Score

7 During the last **3 months** …

how much has *the problem with your shoulder* interfered with your social life? (including sexual activity – if applicable)

Not at all	Occasionally	Some days	Most days	Every day
☐	☐	☐	☐	☐

8 During the last **4 weeks** …

how much has *the problem with your shoulder* interfered with your sporting activities or hobbies?

Not at all	A little/ occasionally	Some of the time	Most of the time	All of the time
☐	☐	☐	☐	☐

9 During the last **4 weeks** …

how often has your shoulder been 'on your mind' – how often have you thought about it?

Never, or only if someone asks	Occasionally	Some days	Most days	Every day
☐	☐	☐	☐	☐

10 During the last **4 weeks** …

how much has *the problem with your shoulder* interfered with your ability – or willingness – to lift heavy objects?

Not at all	Occasionally	Some days	Most days	Every day
☐	☐	☐	☐	☐

11 During the last **4 weeks** …

how would you describe the pain you *usually* had from your shoulder?

None	Very mild	Mild	Moderate	Severe
☐	☐	☐	☐	☐

12 During the last **4 weeks** …

have you avoided lying in certain positions, in bed at night, *because of your shoulder*?

No nights	Only 1 or 2 nights	Some nights	Most nights	Every night
☐	☐	☐	☐	☐

Sum = _____

Oxford Shoulder Score

PROBLEMS WITH YOUR SHOULDER

Tick (✓) one box for every question.

1. During the past 4 weeks...

How would you describe the **worst** pain you had from your shoulder?

None	Mild	Moderate	Severe	Unbearable
☐	☐	☐	☐	☐

2. During the past 4 weeks...

Have you had any trouble dressing yourself because of your shoulder?

No trouble at all	A little bit of trouble	Moderate trouble	Extreme difficulty	Impossible to do
☐	☐	☐	☐	☐

3. During the past 4 weeks...

Have you had any trouble getting in and out of a car or using public transport because of your shoulder?

No trouble at all	A little bit of trouble	Moderate trouble	Extreme difficulty	Impossible to do
☐	☐	☐	☐	☐

4. During the past 4 weeks...

Have you been able to use a knife and fork - at the same time?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
☐	☐	☐	☐	☐

5. During the past 4 weeks...

Could you do the household shopping on your own?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
☐	☐	☐	☐	☐

6. During the past 4 weeks...

Could you carry a tray containing a plate of food across a room?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
☐	☐	☐	☐	☐

7. During the past 4 weeks...

Could you brush/comb your hair with the affected arm?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
☐	☐	☐	☐	☐

8. During the past 4 weeks...

How would you describe the pain you usually had from your shoulder?

None	Very mild	Mild	Moderate	Severe
☐	☐	☐	☐	☐

9. During the past 4 weeks...

Could you hang your clothes up in a wardrobe, using the affected arm?

Yes, easily	With little difficulty	With moderate difficulty	With great difficulty	No, impossible
☐	☐	☐	☐	☐

10. During the past 4 weeks...

Have you been able to wash and dry yourself under both arms?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
☐	☐	☐	☐	☐

11. During the past 4 weeks...

How much has pain from your shoulder interfered with your usual work (including housework)?

Not at all	A little bit	Moderately	Greatly	Totally
☐	☐	☐	☐	☐

12. During the past 4 weeks...

Have you been troubled by pain from your shoulder in bed at night?

No nights	Only 1 or 2 nights	Some nights	Most nights	Every night
☐	☐	☐	☐	☐

Finally, please check back that you have answered each question.
Thank you very much.

Sum = Oxford Shoulder Score = _____

Interpreting the Oxford Shoulder Score

Score 0 to 19	May indicate severe shoulder arthri is. It is highly likely that you may well require some form of surgical intervention, contact your family physician for a consult with an Orthopaedic Surgeon.
Score 20 to 29	May indicate moderate to severe shoulder arthritis. See your family physician for an assessment and x-ray. Consider a consult with an Orthopaedic Surgeon.
Score 30 to 39	May indicate mild to moderate shoulder arthritis. Consider seeing you family physician for an assessment and possible x-ray. You may benefit from non-surgical treatment, such as exercise, weight loss, and /or anti-inflammatory medication
Score 40 to 48	May indicate satisfactory joint function. May not require any formal treatment.

Reference for Score: Dawson J, Fitzpatrick R, Carr A. Questionnaire on the perceptions of patients about shoulder Surgery. J Bone Joint Surg Br. 1996 Jul;78(4):593-600.

Simple Shoulder Test

Dominant Hand (fill in only one oval): Right ⬭ Left ⬭ Ambidextrous ⬭

Shoulder Evaluated (fill in only one oval): Right ⬭ Left ⬭

		Yes	No
1.	Is your shoulder comfortable with your arm at rest by your side?	⬭	⬭
2.	Does your shoulder allow you to sleep comfortably?	⬭	⬭
3.	Can you reach the small of your back to tuck in your shirt with your hand?	⬭	⬭
4.	Can you place your hand behind your head with the elbow straight out to the side?	⬭	⬭
5.	Can you place a coin on a shelf at the level of your shoulder without bending your elbow?	⬭	⬭
6.	Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?	⬭	⬭
7.	Can you lift eight pounds (a full gallon container) to the level of your shoulder without bending your elbow?	⬭	⬭
8.	Can you carry twenty pounds at your side with the affected extremity?	⬭	⬭
9.	Do you think you can toss a softball under-hand twenty yards with the affected extremity?	⬭	⬭
10.	Do you think you can toss a softball over-hand twenty yards with the affected extremity?	⬭	⬭
11.	Can you wash the back of your opposite shoulder with the affected extremity?	⬭	⬭
12.	Would your shoulder allow you to work full-time at your regular job?	⬭	⬭

*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{(sum of n responses)}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.

Carpal Tunnel Syndrome **Questionnaire**

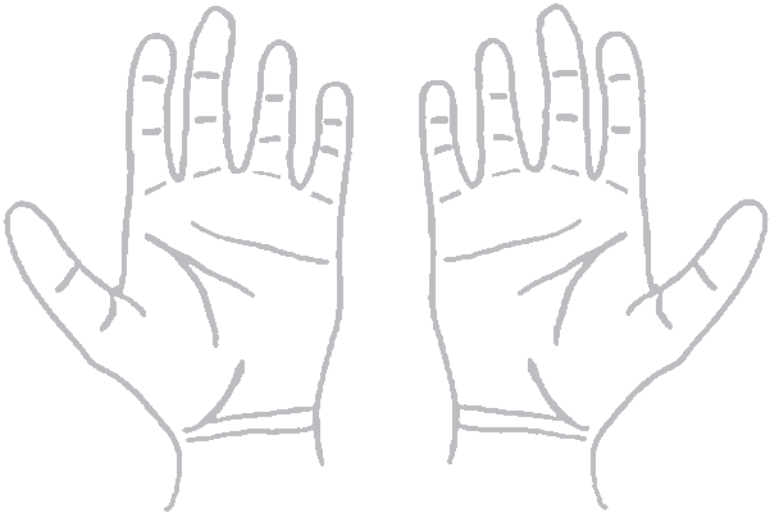
The following questions refer to your RIGHT or LEFT hand symptoms in a typical 24 hour period during the PAST WEEK. Circle your answers.

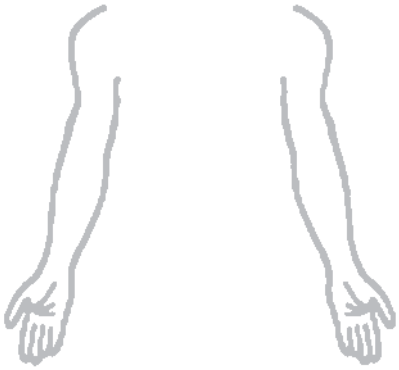
QUESTION 1 How severe is the hand or wrist pain you have at NIGHT?	No Pain at Night 1	Mild Pain 2	Moderate Pain 3	Severe Pain 4	Very Severe Pain 5
QUESTION 2 How often did hand or wrist pain at NIGHT wake you up during a typical night in the past week?	Never 1	Once 2	Two to three times 3	Four to five times 4	More than five times 5
QUESTION 3 Do you typically have pain in your hand or wrist during the DAYTIME?	Never 1	Once or twice a day 2	Three to five times a day 3	More than five times a day 4	Pain is constant 5
QUESTION 4 How severe is the hand or wrist pain you have at NIGHT?	Never 1	Mild Pain 2	Moderate Pain 3	Severe Pain 4	Very Severe Pain 5
QUESTION 5 How long, on average, does an episode of pain last during the daytime?	I never get pain during the day 1	10 minutes or less 2	10 to 60 minutes 3	Greater than 60 minutes 4	Pain is constant throughout the day 5
QUESTION 6 Do you have numbness (loss of sensation) in your hand?	No 1	Mild 2	Moderate 3	Severe 4	Very Severe 5
QUESTION 7 Do you have weakness in your hand or wrist?	No 1	Mild 2	Moderate 3	Severe 4	Very Severe 5
QUESTION 8 Do you have tingling sensations in your hand?	No 1	Mild 2	Moderate 3	Severe 4	Very Severe 5
QUESTION 9 How severe is numbness (loss of sensation) or tingling at night?	No 1	Mild 2	Moderate 3	Severe 4	Very Severe 5
QUESTION 10 How often did hand numbness or tingling wake you up during a typical night during the PAST WEEK?	Never 1	Once 2	Two to three times 3	Four to five times 4	More than five times 5
QUESTION 11 Do you have difficulty with grasping and using small objects such as keys or pens?	No 1	Mild 2	Moderate 3	Severe 4	Very Severe 5

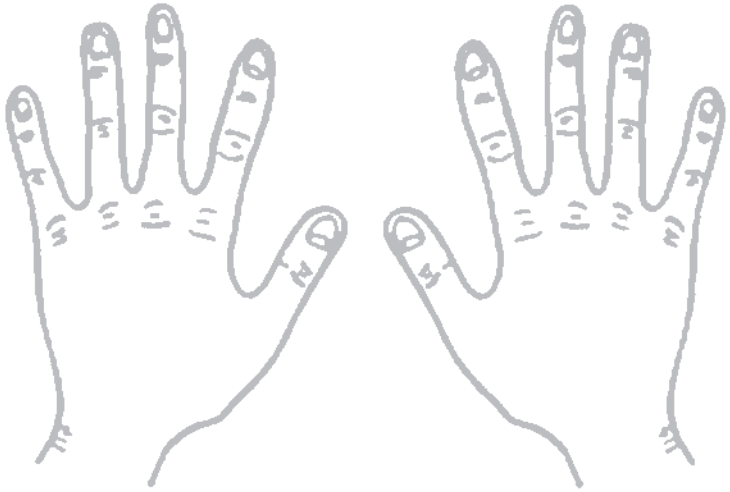
TO SCORE: add up the numbers you have circled, then divide the total by 11.
This should result in a number between 1 and 5. That is your "symptom" score.

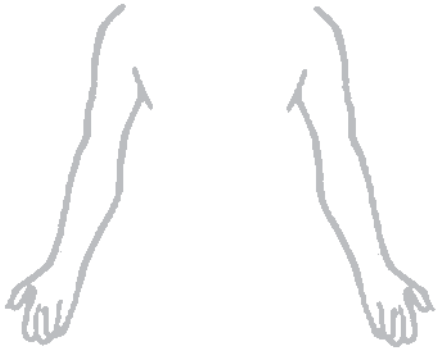
Carpal Tunnel Syndrome **Diagrams**

Using the symbols indicated, mark the areas on your hands where you feel the described sensations.

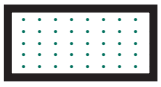




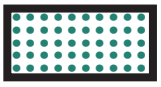




Pain



Tingling



Numbness

Decreased sensation

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

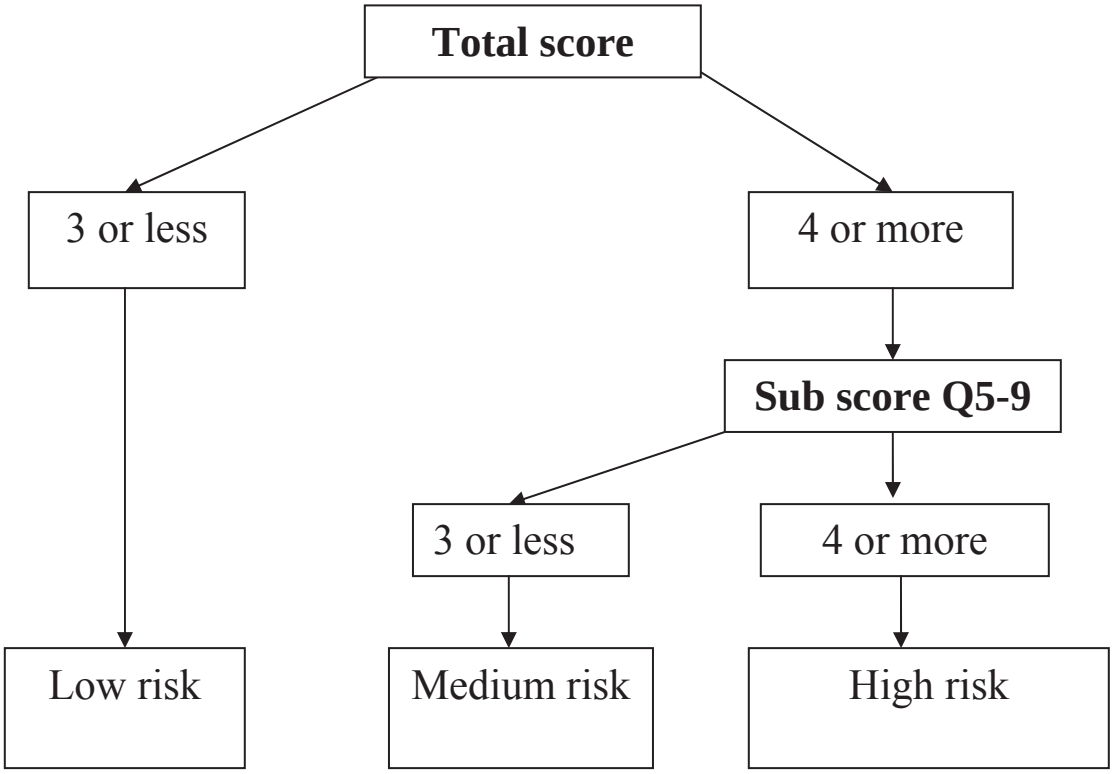
		No 0	**Yes** 1
1	Has your back pain spread down your leg(s) at some time in the last 2 weeks?	☐	☐
2	Have you had pain in the shoulder or neck at some time in the last 2 weeks?	☐	☐
3	Have you only walked short distances because of your back pain?	☐	☐
4	In the last 2 weeks, have you dressed more slowly than usual because of back pain?	☐	☐
5	Do you think it's not really safe for a person with a condition like yours to be physically active?	☐	☐
6	Have worrying thoughts been going through your mind a lot of the time?	☐	☐
7	Do you feel that your back pain is terrible and it's never going to get any better?	☐	☐
8	In general have you stopped enjoying all the things you usually enjoy?	☐	☐

9. Overall, how **bothersome** has your back pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ Sub Score (Q5-9):_____

The STarT Tool Scoring System



Harris Hip Score

Name	
Hip:	☐ Left ☐ Right
Examination Date (MM/DD/YY):	/ /
Date of Surgery (MM/DD/YY):	/ /
Today's Date (MM/DD/YY):	/ /

Interval: _____

Harris Hip Score

Pain *(check one)*

- ☐ None or ignores it (44)
- ☐ Slight, occasional, no compromise in activities (40)
- ☐ Mild pain, no effect on average activities, rarely moderate pain with unusual activity; may take aspirin (30)
- ☐ Moderate Pain, tolerable but makes concession to pain. Some limitation of ordinary activity or work. May require Occasional pain medication stronger than aspirin (20)
- ☐ Marked pain, serious limitation of activities (10)
- ☐ Totally disabled, crippled, pain in bed, bedridden (0)

Limp

- ☐ None (11)
- ☐ Slight (8)
- ☐ Moderate (5)
- ☐ Severe (0)

Support

- ☐ None (11)
- ☐ Cane for long walks (7)
- ☐ Cane most of time (5)
- ☐ One crutch (3)
- ☐ Two canes (2)
- ☐ Two crutches or not able to walk (0)

Distance Walked

- ☐ Unlimited (11)
- ☐ Six blocks (8)
- ☐ Two or three blocks (5)
- ☐ Indoors only (2)
- ☐ Bed and chair only (0)

Sitting

- ☐ Comfortably in ordinary chair for one hour (5)
- ☐ On a high chair for 30 minutes (3)
- ☐ Unable to sit comfortably in any chair (0)

Enter public transportation

- ☐ Yes (1)
- ☐ No (0)

Stairs

- ☐ Normally without using a railing (4)
- ☐ Normally using a railing (2)
- ☐ In any manner (1)
- ☐ Unable to do stairs (0)

Put on Shoes and Socks

- ☐ With ease (4)
- ☐ With difficulty (2)
- ☐ Unable (0)

Absence of Deformity (All yes = 4; Less than 4 =0)

- Less than 30° fixed flexion contracture ☐ Yes ☐ No
- Less than 10° fixed abduction ☐ Yes ☐ No
- Less than 10° fixed internal rotation in extension ☐ Yes
- ☐ No Limb length discrepancy less than 3.2 cm ☐ Yes

Range of Motion (**indicates normal)*

- Flexion (*140°) _____
- Abduction (*40°) _____
- Adduction (*40°) _____
- External Rotation (*40°) _____
- Internal Rotation (*40°) _____

Range of Motion Scale

211° - 300° (5)	61° - 100 (2)
161° - 210° (4)	31° - 60° (1)
101° - 160° (3)	0° - 30° (0)

Range of Motion Score _____

Total Harris Hip Score _____

KOOS, JR. KNEE SURVEY

INSTRUCTIONS: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to do your usual activities.
Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Stiffness
The following question concerns the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

1. How severe is your knee stiffness after first wakening in the morning?

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

Pain
What amount of knee pain have you experienced the **last week** during the following activities?

2. Twisting/pivoting on your knee

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

3. Straightening knee fully

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

4. Going up or down stairs

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

5. Standing upright

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

Function, daily living
The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

6. Rising from sitting

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

7. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

KOOS, JR SCORING INSTRUCTIONS

The KOOS, JR was developed from the original long version of the Knee injury and Osteoarthritis Outcome Score (KOOS) survey using Rasch analysis. The KOOS, JR contains 7 items from the original KOOS survey. Items are coded from 0 to 4, none to extreme respectively.

KOOS, JR is scored by summing the raw response (range 0-28) and then converting it to an interval score using the table provided below. The interval score ranges from 0 to 100 where 0 represents total knee disability and 100 represents perfect knee health.

Table for converting raw summed scores to interval level scores from 0 (total knee disability) to 100 (perfect knee health)

Raw summed score (0-28)	Interval score (0 to 100 scale)
0	100.000
1	91.975
2	84.600
3	79.914
4	76.332
5	73.342
6	70.704
7	68.284
8	65.994
9	63.776
10	61.583
11	59.381
12	57.140
13	54.840
14	52.465
15	50.012
16	47.487
17	44.905
18	42.281
19	39.625
20	36.931
21	34.174
22	31.307
23	28.251
24	24.875
25	20.941
26	15.939
27	8.291
28	0.000

Head Injury Symptom Scale

Directions:
Patient: After reading each symptom, please circle the number which best describes the way you have been feeling **today.** A rating of **0** means you have **not** experienced this symptom today. A rating of **6** means you have experienced **severe** problems with this symptom today.
Then, answer the questions at the bottom of the form.

Clinician: Review, sign, and send to medical records for scanning.

	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
“Pressure in head”	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or Vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like “in a fog”	0	1	2	3	4	5	6
“Don’t feel right”	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble Falling Asleep (if applicable)	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6

Total number of symptoms: _____ of 22 Symptom severity score: _____ of 132

Do your symptoms get worse with physical activity? Circle Yes / No ?
Do your symptoms get worse with mental activity? Circle Yes / No ?
If 100% is feeling perfectly normal, what percent of normal do you feel? _____
If not 100%, why?
_____
_____

Date _____ Clinician Signature _____

Headache Disability Index

Date _____

Patient Name: _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO	
_____	_____	_____	Because of my headaches I feel disabled.
_____	_____	_____	Because of my headaches I feel restricted in performing my routine daily activities.
_____	_____	_____	No one understands the effect my headaches have on my life.
_____	_____	_____	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
_____	_____	_____	My headaches make me angry.
_____	_____	_____	Sometimes I feel that I am going to lose control because of my headaches.
_____	_____	_____	Because of my headaches I am less likely to socialize.
_____	_____	_____	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
_____	_____	_____	My headaches are so bad that I feel that I am going to go insane.
_____	_____	_____	My outlook on the world is affected by my headaches.
_____	_____	_____	I am afraid to go outside when I feel that a headaches is starting.
_____	_____	_____	I feel desperate because of my headaches.
_____	_____	_____	I am concerned that I am paying penalties at work or at home because of my headaches.
_____	_____	_____	My headaches place stress on my relationships with family or friends.
_____	_____	_____	I avoid being around people when I have a headache.
_____	_____	_____	I believe my headaches are making it difficult for me to achieve my goals in life.
_____	_____	_____	I am unable to think clearly because of my headaches.
_____	_____	_____	I get tense (eg, muscle tension) because of my headaches.
_____	_____	_____	I do not enjoy social gatherings because of my headaches.
_____	_____	_____	I feel irritable because of my headaches.
_____	_____	_____	I avoid traveling because of my headaches.
_____	_____	_____	My headaches make me feel confused.
_____	_____	_____	My headaches make me feel frustrated.
_____	_____	_____	I find it difficult to read because of my headaches.
_____	_____	_____	I find it difficult to focus my attention away from my headaches and on other things.

Instructions: 1. Using this system, if "YES" is checked on any given line, that answer is given 4 points... a "SOMETIMES" answer is given 2 points and a "NO" answer is given zero. 2. Using this system, a score of 10-28% is considered to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

Patient's Signature: _____ Date: _____

Head Injury Daily Checklist

Instructions: Each day, grade the 22 symptoms listed with a score of 0 through 6. Add the total at the bottom to create your total score for that day.

None	Mild		Moderate		Severe	
0	1	2	3	4	5	6

TODAY'S DATE							
Headache							
"Pressure in head"							
Neck Pain							
Nausea or vomiting							
Dizziness							
Blurred vision							
Balance problems							
Sensitivity to light							
Sensitivity to noise							
Feeling slowed down							
Feeling like "in a fog"							
"Don't feel right"							
Difficulty concentrating							
Difficulty remembering							
Fatigue or low energy							
Confusion							
Drowsiness							
Trouble falling asleep (if applicable)							
More emotional							
Irritability							
Sadness							
Nervous or Anxious							
Total Score							

Head Injury Symptom Scale

Directions:
Patient: After reading each symptom, please circle the number which best describes the way you have been feeling **today.** A rating of **0** means you have **not** experienced this symptom today. A rating of **6** means you have experienced **severe** problems with this symptom today.
Then, answer the questions at the bottom of the form.

Clinician: Review, sign, and send to medical records for scanning.

	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or Vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble Falling Asleep (if applicable)	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6

Total number of symptoms: _____ of 22 Symptom severity score: _____ of 132

Do your symptoms get worse w/ physical activity? Y / N?
Do your symptoms get worse with mental activity? Y / N
If 100% is feeling perfectly normal, what percent of normal do you feel? _____
If not 100%, why?

_____

_____

_____
Clinician Signature

Check our Website: uhs.berkeley.edu **to learn more about this and other medical concerns.**
For **Appointments**: etang.berkeley.edu or call 510-642-2000 | For **Advice:** call 510-643-7197

University of California, Berkeley
2222 Bancroft Way
Berkeley, CA 94720

Head Injury/Concussion

You have been diagnosed with a concussion. This handout is designed to help you recover safely and prevent further injury. If your symptoms worsen in the first 24 hours after the injury, you may need to seek urgent medical care, so stay with a reliable friend or relative during that time period.

A concussion is a traumatic brain injury that alters your brain function. It is common to experience physical symptoms (like headaches, dizziness, fatigue), cognitive symptoms (like difficulty concentrating/focusing, memory deficits), emotional symptoms and sleep disturbances. Most concussions resolve in 7-10 days. Tests like CT scans and MRIs are most often not necessary to diagnose and treat a concussion.

Warning Signs

If your injury is worsening in any way, including:

- Inability to wake up
- Severe/worsening headache
- Confusion
- Worsening balance problems
- Seizures (convulsions)
- Changes in vision or double vision
- Problems talking or slurred speech
- Repeated vomiting (at least 2 episodes)
- Stiff neck (cannot bend chin to chest)
- Weakness or numbness in any part of the body
- Changes in personality/behavior

... ***You should seek emergency medical care.***

Home Care Recommendations

- Record your symptoms daily on the attached "symptom scale" form to monitor your progress.
- **Rest your brain**: Avoid any activity which increases symptoms. You may need to modify school/work attendance and workload as well as avoid texting, videogames and computer or television usage.
  - See Return-to-Learn Guidelines on the following page.
  - If you have trouble with coursework accommodations, call Social Services at Tang (510-642-6074) for advice.
- **Rest your body**: Avoid any exertion which increases symptoms. Resume normal activities gradually, and as tolerated. Avoid pulling "all nighters" as sleep will help recovery. Take naps or rest breaks when you feel tired or fatigued.
- Only take medication as recommended by your clinician. Acetaminophen (Tylenol) is the preferred medicine for pain after the injury. Avoid aspirin, ibuprofen and naproxen unless recommended by your clinician.
- Avoid drinking alcohol or taking illicit drugs, sleeping pills, or other substances that change your thinking and/or might worsen your symptoms.

Return-to-Learn Guidelines

Following a concussion, return to studying and the classroom should take place in a step-wise manner. Please note that the rate in which each student progresses will vary and should be individualized. The general progression is as follows:

1) Start with 5-15 minutes of daily activities that do not increase symptoms; gradually increase the time.
2) Once you are able to tolerate 30 minutes of cognitive activity, it is ok to resume modified class attendance (modified class attendance options include attending the first 30 minutes of classes, breaks between classes, half-days, etc)
3) Once you have returned to class you may increase load as tolerated. If you experience an exacerbation of symptoms, return back to previous level of cognitive activity where you had no symptoms and try to progress again after 24 hours

Major exams may not be representative of academic ability in the immediate post-concussive period. We recommend no finals/major exams or projects for 7 days following the diagnosis of concussion.

Return to Sports/Activity

The injured person should never return to sports or active recreation with any persisting symptoms of a concussion and should not return to any activity until evaluated by a clinician. When all symptoms have resolved at rest, follow a stepwise, symptom-limited program to return to sports activity outlined below.. There should be at least 24 hours for each stage. If symptoms recur at any stage, you should stop all activity and make a follow-up appointment.

Stages 1 through 6:

1. Limit to daily activities that don't provoke symptoms.
2. Light exercise: stationary biking, walking, or light jogging for 10-20 minutes. (Absolutely no weight lifting, jumping or hard running).
3. Moderate exercise with body/head movement: moderate jogging, brief running, moderate-intensity stationary biking; time should be reduced from your normal exercise routine. Light weightlifting may be added at this step as well.
4. Non-contact exercise: running, high-intensity stationary biking, your regular weightlifting routine, and non-contact sport-specific drills (eg, shooting, passing, throwing); time should be close to your normal exercise routine.
5. Full-contact training/activity: regular exercise routine or practice. **If you participate in sports such as basketball, volleyball, baseball/softball, lacrosse, or any Intramural or Club sports you should be cleared by a medical professional prior to this step.**
6. Return to full competition/games.

Post–Concussion Syndrome

Sometimes after even a minor head injury, people notice persisting symptoms of a concussion (some examples are listed below). Talk to your doctor if these symptoms are worsening, or if they persist more than 7-10 days.

- Difficulty concentrating; feeling mentally foggy
- Difficulty learning and memory problems
- Vision changes
- Headaches, especially with stress or physical activity
- Mood changes (irritability, sadness, nervousness, more emotional)
- Increased sensitivity to noise or light
- Dizziness, balance problems, or nausea
- Unusual fatigue; feeling tired; drowsiness or change in sleep patterns
- Difficulty in relationships with other people
- Increased susceptibility to alcohol (becoming drunk more easily)

Patient Version

MICHIGAN NEUROPATHY SCREENING INSTRUMENT

A. History (To be completed by the person with diabetes)

Please take a few minutes to answer the following questions about the feeling in your legs and feet. Check yes or no based on how you usually feel. Thank you.

1.	Are you legs and/or feet numb?	☐ Yes	☐ No
2.	Do you ever have any burning pain in your legs and/or feet?	☐ Yes	☐ No
3.	Are your feet too sensitive to touch?	☐ Yes	☐ No
4.	Do you get muscle cramps in your legs and/or feet?	☐ Yes	☐ No
5.	Do you ever have any prickling feelings in your legs or feet?	☐ Yes	☐ No
6.	Does it hurt when the bed covers touch your skin?	☐ Yes	☐ No
7.	When you get into the tub or shower, are you able to tell the hot water from the cold water?	☐ Yes	☐ No
8.	Have you ever had an open sore on your foot?	☐ Yes	☐ No
9.	Has your doctor ever told you that you have diabetic neuropathy?	☐ Yes	☐ No
10.	Do you feel weak all over most of the time?	☐ Yes	☐ No
11.	Are your symptoms worse at night?	☐ Yes	☐ No
12.	Do your legs hurt when you walk?	☐ Yes	☐ No
13.	Are you able to sense your feet when you walk?	☐ Yes	☐ No
14.	Is the skin on your feet so dry that it cracks open?	☐ Yes	☐ No
15.	Have you ever had an amputation?	☐ Yes	☐ No

Total: _____

MICHIGAN NEUROPATHY SCREENING INSTRUMENT

B. Physical Assessment (To be completed by health professional)

1. Appearance of Feet

	Right	**Left**
a. Normal	☐ 0 Yes ☐ 1 No	Normal ☐ 0 Yes ☐ 1 No
b. If no, check all that apply:		If no, check all that apply:
Deformities	☐	Deformities ☐
Dry skin, callus	☐	Dry skin, callus ☐
Infection	☐	Infection ☐
Fissure	☐	Fissure ☐
Other	☐	Other ☐
specify: _____		specify: _____

	Right		**Left**	
	Absent	Present	Absent	Present
2. Ulceration	☐ 0	☐ 1	☐ 0	☐ 1

	Right			**Left**		
	Present	Present/ Reinforcement	Absent	Present	Present/ Reinforcement	Absent
3. Ankle Reflexes	☐ 0	☐ 0.5	☐ 1	☐ 0	☐ 0.5	☐ 1
	Present	Decreased	Absent	Present	Decreased	Absent
4. Vibration perception at great toe	☐ 0	☐ 0.5	☐ 1	☐ 0	☐ 0.5	☐ 1
	Normal	Reduced	Absent	Normal	Reduced	Absent
5. Monofilament	☐ 0	☐ 0.5	☐ 1	☐ 0	☐ 0.5	☐ 1

Signature:_____ Total Score _____ /10 Points

How to Use the Michigan Neuropathy Screening Instrument

History

The history questionnaire is self-administered by the patient. Responses are added to obtain the total score. Responses of "yes" to items 1-3, 5-6, 8-9, 11-12, 14-15 are each counted as one point. A "no" response on items 7 and 13 counts as 1 point. Item #4 is a measure of impaired circulation and item #10 is a measure of general aesthenia and are not included in scoring. To decrease the potential for bias, all scoring information has been eliminated from the patient version.

Physical Assessment

For all assessments, the foot should be warm (>30°C).

Foot Inspection: The feet are inspected for evidence of excessively dry skin, callous formation, fissures, frank ulceration or deformities. Deformities include flat feet, hammer toes, overlapping toes, halux valgus, joint subluxation, prominent metatarsal heads, medial convexity (Charcot foot) and amputation.

Vibration Sensation: Vibration sensation should be performed with the great toe unsupported. Vibration sensation will be tested bilaterally using a 128 Hz tuning fork placed over the dorsum of the great toe on the boney prominence of the DIP joint. Patients, whose eyes are closed, will be asked to indicate when they can no longer sense the vibration from the vibrating tuning fork.

In general, the examiner should be able to feel vibration from the hand-held tuning fork for 5 seconds longer on his distal forefinger than a normal subject can at the great toe (e.g. examiner's DIP joint of the first finger versus patient's toe). If the examiner feels vibration for 10 or more seconds on his or her finger, then vibration is considered decreased. A trial should be given when the tuning fork is not vibrating to be certain that the patient is responding to vibration and not pressure or some other clue. Vibration is scored as 1) present if the examiner senses the vibration on his or her finger for < 10 seconds, 2) reduced if sensed for ≥ 10 or 3) absent (no vibration detection.)

Muscle Stretch Reflexes: The ankle reflexes will be examined using an appropriate reflex hammer (e.g. Trommer or Queen square). The ankle reflexes should be elicited in the sitting position with the foot dependent and the patient relaxed. For the reflex, the foot should be passively positioned and the foot dorsiflexed slightly to obtain optimal stretch of the muscle. The Achilles tendon should be percussed directly. If the reflex is obtained, it is graded as present. If the reflex is absent, the patient is asked to perform the Jendrassic maneuver (i.e., hooking the fingers together and pulling). Reflexes elicited with the Jendrassic maneuver alone are designated "present with reinforcement." If the

reflex is absent, even in the face of the Jendrassic maneuver, the reflex is considered absent.

Monofilament Testing: For this examination, it is important that the patient's foot be supported (i.e., allow the sole of the foot to rest on a flat, warm surface). The filament should initially be prestressed (4-6 perpendicular applications to the dorsum of the examiner's first finger). The filament is then applied to the dorsum of the great toe midway between the nail fold and the DIP joint. Do not hold the toe directly. The filament is applied perpendicularly and briefly, (<1 second) with an even pressure. When the filament bends, the force of 10 grams has been applied. The patient, whose eyes are closed, is asked to respond yes if he/she feels the filament. Eight correct responses out of 10 applications is considered normal: one to seven correct responses indicates reduced sensation and no correct answers translates into absent sensation.

Scripps Neurological Rating Scale

System Examined	Degree of Impairment			
	Normal	Mild	Moderate	Severe
Mentation and Mood	10	7	4	0
Cranial Nerves				
Visual Acuity	5	3	1	0
Fields, Discs, Pupils	6	4	2	0
Eye Movements	5	3	1	0
Nystagmus	5	3	1	0
Lower Cranial Nerves	5	3	1	0
Motor				
RU	5	3	1	0
LU	5	3	1	0
RL	5	3	1	0
LL	5	3	1	0
DTRS				
UE	4	3	1	0
LE	4	3	1	0
Babinski				
R	2	0	0	0
L	2	0	0	0
Sensory				
RU	3	2	1	0
LU	3	2	1	0
RL	3	2	1	0
LL	3	2	1	0
Cerebellar				
UE	5	3	1	0
LE	5	3	1	0
Gait; Trunk and Balance	10	7	4	0
Special Category				
Bladder/Bowel/ Sexual Dysfunction	0	-3	-7	-10
OVERALL SNRS SCORE (Maximum = 100)				

Folstein Mini Mental State Evaluation

J Psychiatr Res 1975; 12: 189-196

Patient's Name:_____ Date:_____

Instructions: Ask the questions in the order listed.
Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: _____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		**TOTAL**

VAMC
SLUMS Examination

Questions about this assessment tool? E-mail aging@slu.edu.

Name _____ Age _____

Is patient alert? _____ Level of education _____

__/1 (1) **1. What day of the week is it?**

__/1 (1) **2. What is the year?**

__/1 (1) **3. What state are we in?**

4. Please remember these five objects. I will ask you what they are later.

Apple Pen Tie House Car

5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.

(1) **How much did you spend?**

__/3 (2) **How much do you have left?**

6. Please name as many animals as you can in one minute.

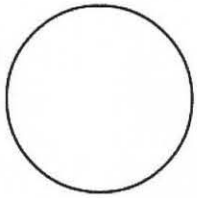
__/3 (0) 0-4 animals (1) 5-9 animals (2) 10-14 animals (3) 15+ animals

__/5 **7. What were the five objects I asked you to remember?** 1 point for each one correct.

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.

__/2 (0) 87 (1) 649 (1) 8537

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.



(2) Hour markers okay

__/4 (2) Time correct

__/2 (1) **10. Please place an X in the triangle.**

(1) **Which of the above figures is largest?**

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

(2) **What was the female's name?** (2) **What work did she do?**

__/8 (2) **When did she go back to work?** (2) **What state did she live in?**

_____ **TOTAL SCORE**

Department of Veterans Affairs

SAINT LOUIS UNIVERSITY

AGING SUCCESSFULLY

SCORING

HIGH SCHOOL EDUCATION		LESS THAN HIGH SCHOOL EDUCATION
27-30	Normal	25-30
21-26	MNCD*	20-24
1-20	Dementia	1-19

* Mild Neurocognitive Disorder

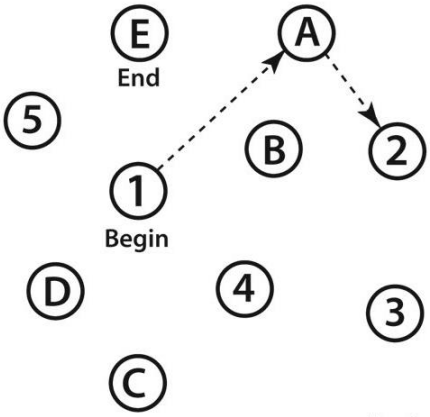
SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for Detecting Mild Cognitive Impairment and Dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. Am J Geriatr Psychiatry 14:900-910, 2006.

MONTREAL COGNITIVE ASSESSMENT (MOCA)

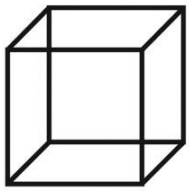
Version 7.1 Original Version

NAME :
Education : Date of birth :
Sex : DATE :

VISUOSPATIAL / EXECUTIVE



Copy cube



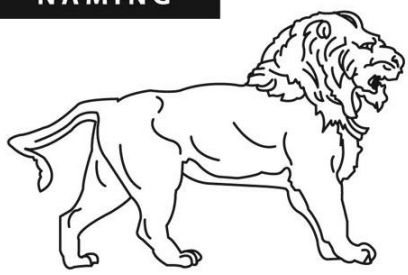
[ ] [ ]

Draw CLOCK (Ten past eleven)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands

POINTS ___/5

NAMING



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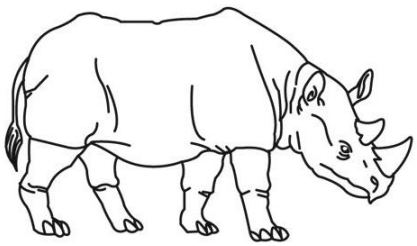

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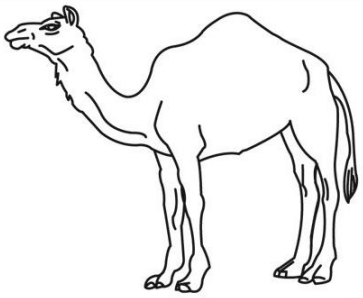


[ ]

___/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION

Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order [ ] 2 1 8 5 4

Subject has to repeat them in the backward order [ ] 7 4 2

___/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

___/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

___/3

LANGUAGE

Repeat : I only know that John is the one to help today. [ ]

The cat always hid under the couch when dogs were in the room. [ ]

___/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words)

___/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler

___/2

DELAYED RECALL

	Has to recall words **WITH NO CUE**	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

___/5

ORIENTATION

[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

___/6

www.mocatest.org

Normal ≥ 26 / 30

TOTAL ___/30

Add 1 point if ≤ 12 yr edu

Administered by: _____

MFI® MULTIDIMENSIONAL FATIGUE INVENTORY

Instructions:

By means of the following statements we would like to get an idea of how you have been feeling **lately**. There is, for example, the statement:

"I FEEL RELAXED"

If you think that this is **entirely true**, that indeed you have been feeling relaxed lately, please, place an **X** in the extreme left box; like this:

yes, that is true ☒1 ❑2 ❑3 ❑4 ❑5 **no, that is not true**

The more you **disagree** with the statement, the more you can place an **X** in the direction of "no, that is not true". Please do not miss out a statement and place only one **X** in a box for each statement.

1	I feel fit.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
2	Physically, I feel only able to do a little.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
3	I feel very active.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
4	I feel like doing all sorts of nice things.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
5	I feel tired.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
6	I think I do a lot in a day.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
7	When I am doing something, I can keep my thoughts on it.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
8	Physically I can take on a lot.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
9	I dread having to do things.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
10	I think I do very little in a day.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
11	I can concentrate well.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
12	I am rested.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
13	It takes a lot of effort to concentrate on things.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
14	Physically I feel I am in a bad condition.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
15	I have a lot of plans.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
16	I tire easily.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
17	I get little done.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
18	I don't feel like doing anything.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
19	My thoughts easily wander.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true
20	Physically I feel I am in an excellent condition.	yes, that is true	❑1	❑2	❑3	❑4	❑5	no, that is not true

Fatigue Severity Scale

The Fatigue Severity Scale (FSS) is a method of evaluating fatigue in multiple sclerosis and other conditions including Chronic Fatigue Immune Dysfunction Syndrome (CFIDS) and Systemic Lupus Erythmatosis (SLE).

The Fatigue Severity Scale (FSS) is designed to differentiate fatigue from clinical depression, since both share some of the same symptoms. Essentially, the FSS consists of answering a short questionaire that requires the subject to rate his or her own level of fatigue. The obvious problem with this measure is its subjectivity.

Here is an example FSS questionaire containing nine statements that attempt to explore severity of fatigue symptoms. The subject is asked to read each statement and circle a number from 1 to 7, depending on how appropriate they felt the statement applied to them over the preceding week. A low value indicates that the statement is not very appropriate whereas a high value indicates agreement.

FSS Questionaire

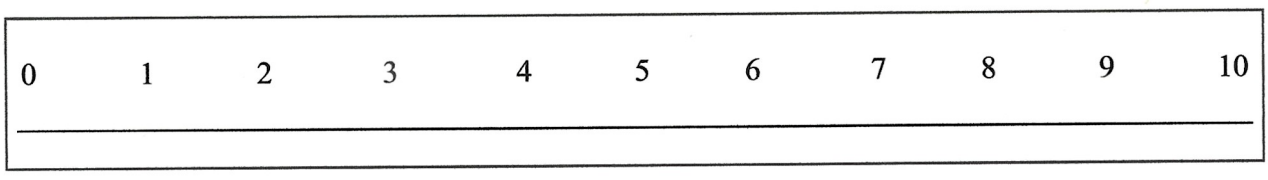
During the past week, I have found that:	**Score**						
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7

The scoring is done by calculating the average response to the questions (adding up all the answers and dividing by nine).

People with depression alone score about 4.5. But people with fatigue related to MS, SLE or CFIDS average about 6.5.

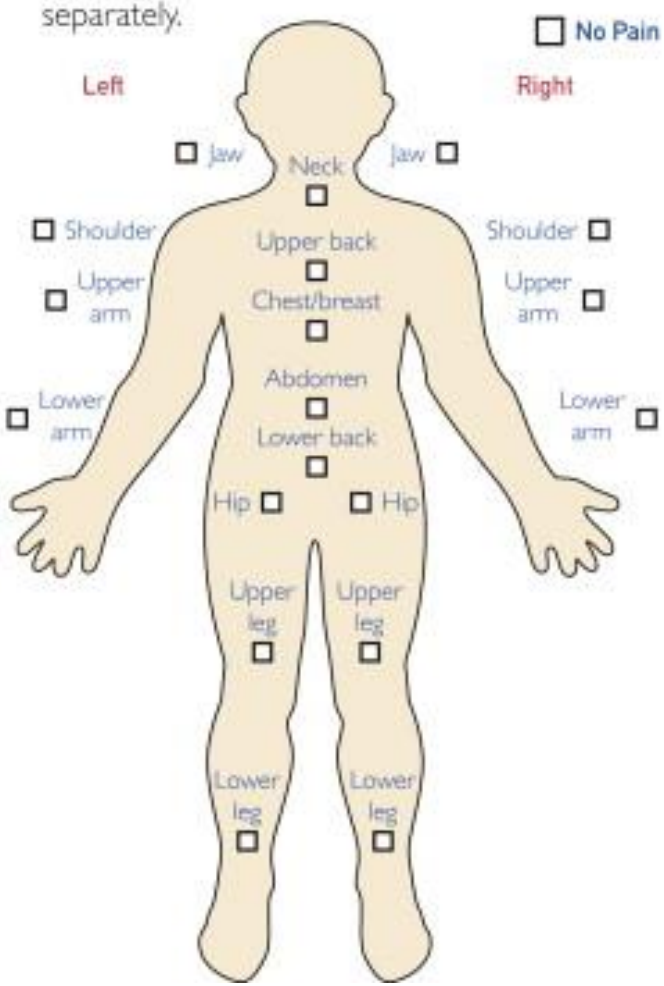
VISUAL ANALOGUE FATIGUE SCALE (VAFS)

Please mark an "X" on the number line which describes your global fatigue with 0 being worst and 10 being normal.



Fibromyalgia Symptoms (Modified ACR 2011 Fibromyalgia Diagnostic Criteria)

1. Please indicate below if you have had pain or tenderness over the past 7 days in each of the areas listed below. Check the boxes in the diagram below for each area in which you have had pain or tenderness. Be sure to mark right and left sides separately.



2. Using the following scale, indicate for each item your severity over the past week by checking the appropriate box.

0 **No problem**
1 **Slight or mild problems**: generally mild or intermittent
2 **Moderate**: considerable problems; often present and/or at a moderate level
3 **Severe**: continuous, life-disturbing problems

	No problem	Slight or mild	Moderate	Severe
a. Fatigue	☐	☐	☐	☐
b. Trouble thinking or remembering	☐	☐	☐	☐
c. Waking up tired (unrefreshed)	☐	☐	☐	☐

3. During the past 6 months have you had any of the following symptoms?

	No	Yes
a. Pain or cramps in lower abdomen	☐	☐
b. Depression	☐	☐
c. Headache	☐	☐

4. Have the symptoms in questions 2-3 and pain been present at a similar level for at least 3 months? **No** ☐ **Yes** ☐

5. Do you have a disorder that would otherwise explain the pain? **No** ☐ **Yes** ☐

Fibromyalgia Criteria

a. WPI (1.) >= 7 and SSS (2.+3.) >= 5, or
b. WPI (1.) 3-6 and SSS (2.+3.) >= 9

FIBROMYALGIA IMPACT QUESTIONNAIRE (FIQ)

Name: _____ Date: / /

Directions: For questions 1 through 11, please circle the number that best describes how you did overall for the *past week*. If you don't normally do something that is asked, cross the question out.

	Always	Most	Occasionally	Never
Were you able to:				
Do shopping?	*0*	*1*	*2*	*3*
Do laundry with a washer and dryer?	*0*	*1*	*2*	*3*
Prepare meals?	*0*	*1*	*2*	*3*
Wash dishes/cooking utensils by hand?.....	*0*	*1*	*2*	*3*
Vacuum a rug?.....	*0*	*1*	*2*	*3*
Make beds?	*0*	*1*	*2*	*3*
Walk several blocks?	*0*	*1*	*2*	*3*
Visit friends or relatives?	*0*	*1*	*2*	*3*
Do yard work?.....	*0*	*1*	*2*	*3*
Drive a car?	*0*	*1*	*2*	*3*
Climb stairs?	*0*	*1*	*2*	*3*

12. Of the 7 days in the past week, how many days did you feel good?

0 1 2 3 4 5 6 7

13. How many days last week did you miss work, including housework, because of fibromyalgia?

0 1 2 3 4 5 6 7

(continued)

FIBROMYALGIA IMPACT QUESTIONNAIRE (FIQ) – page 2

Directions: For the remaining items, mark the point on the line that best indicates how you felt overall for the past week.

14. When you worked, how much did pain or other symptoms of your fibromyalgia interfere with your ability to do your work, including housework?

No problem with work •___|___|___|___|___|___|___|___|___|___• Great difficulty with work

15. How bad has your pain been?

No pain •___|___|___|___|___|___|___|___|___|___• Very severe pain

16. How tired have you been?

No tiredness •___|___|___|___|___|___|___|___|___|___• Very tired

17. How have you felt when you get up in the morning?

Awoke well rested •___|___|___|___|___|___|___|___|___|___• Awoke very tired

18. How bad has your stiffness been?

No stiffness •___|___|___|___|___|___|___|___|___|___• Very stiff

19. How nervous or anxious have you felt?

Not anxious •___|___|___|___|___|___|___|___|___|___• Very anxious

20. How depressed or blue have you felt?

Not depressed •___|___|___|___|___|___|___|___|___|___• Very depressed

Rheumatoid Arthritis

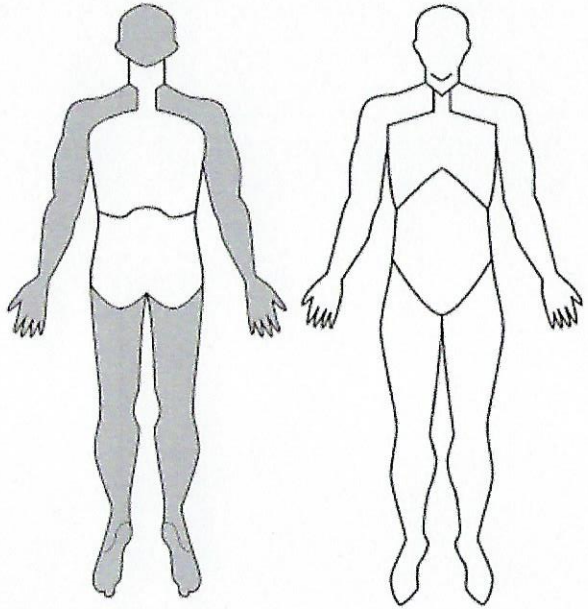
Table I: 2010 ACR/EULAR Classification Criteria for RA	
Joint Involvement	**Score**
1 large joint	0
1-10 large joints	1
1-3 small joints	2
4-10 small joints	3
> 10 joints	5
Serology	
Negative RF and negative ACPA	0
Low-positive RF and low-positive ACPA	2
High-positive RF or high-positive ACPA	3
Acute-phase reactants	
Normal CRP and normal ESR	0
Abnormal CRP or abnormal ESR	1
Duration of symptoms	
< 6 weeks	0
> 6 weeks	1

A patient with score of > 6 is classified as having rheumatoid arthritis (RA).
ACR is the American College of Rheumatology
EULAR is the European League Against Rheumatism
ACPA is anti-citrulliated protein antibody
CRP is C-reactive protein
ESR is erythrocyte sedimentation rate

Fibromyalgia

Table VI: Fibromyalgia Survey Criteria

- Multisite pain defined as six or more pain sites out of a total of nine possible sites (see figure below)
- Moderate to severe sleep problems or fatigue
- Multisite pain, plus fatigue or sleep problems present for at least 3 months



BACK FRONT

☐ Head	☐ Upper back and spine
☐ Left arm	☐ Lower back and spine, including buttocks
☐ Right arm	☐ Left leg
☐ Chest	☐ Right leg
☐ Abdomen	

Modified from References 8,9

The Idiopathic Environmental Intolerance Symptom Inventory

1. *What is the most important type of environmental agent that you are sensitive to and that causes symptoms? Mark the type that best applies!*

☐ Odorous chemicals ☐ Electromagnetic fields ☐ Indoor environments ("sick buildings")

☐ Noise ☐ Other *Describe this other type of agent:* _____

2. *Which of the following symptoms do you commonly experience when exposed to the environmental agent (e.g., odorous chemicals or electromagnetic fields) to which you are sensitive? Mark all symptoms that apply!*

Airway, mucosae and skin symptoms

- ☐ Asthma or wheezing
- ☐ Shortness of breath
- ☐ Coughing
- ☐ Throat irritation/hoarseness
- ☐ Sneezing
- ☐ Nasal congestion/discharge
- ☐ Postnasal drip
- ☐ Excessive mucus production
- ☐ Eye irritation/burning
- ☐ Skin irritation/redness
- ☐ Other airway, mucosae or skin symptoms (e.g., mucus in lower airways or susceptibility to infections)

  Describe these other symptoms:

  _____

Gastrointestinal symptoms

- ☐ Abdominal gas
- ☐ Abdominal swelling/bloating
- ☐ Other gastrointestinal symptoms (e.g., abdominal pain/cramping or problems digesting food)

  Describe these other symptoms:

  _____

Head-related symptoms

- ☐ Headache
- ☐ Head fullness/pressure
- ☐ Other head-related symptoms (e.g., tender face/sinuses or ringing in ears)

  Describe these other symptoms:

  _____

Cardiac, nausea and dizziness symptoms

- ☐ Heart pounding
- ☐ Chest discomfort
- ☐ Nausea
- ☐ Dizziness/lightheadedness
- ☐ Other cardiac, nausea or dizziness symptoms (e.g., irregular heart beat or rapid heart rate)

  Describe these other symptoms:

  _____

Cognitive and affective symptoms

- ☐ Memory difficulties
- ☐ Concentration difficulties
- ☐ Absent-minded
- ☐ Feeling tired/lethargic
- ☐ Sleep disturbance
- ☐ Feeling tense/nervous
- ☐ Feeling irritable/edgy
- ☐ Feeling depressed
- ☐ Feeling worried
- ☐ Other cognitive or affective symptoms (e.g., loss of motivation or difficulties making decisions)

  Describe these other symptoms:

  _____

Other symptoms

- ☐ Other symptoms of any kind (e.g., feeling off balance or joint pain)

  Describe these other symptoms:

  _____

  _____

Idiopathic Environmental Intolerance Symptom Checklist

Symptom	YES	NO
Anxiety	☐	☐
Arthromyalgia	☐	☐
Asthenia	☐	☐
Attention deficit	☐	☐
Cephalalgia (headache)	☐	☐
Chest tightness	☐	☐
Cough	☐	☐
Cystitis	☐	☐
Decision making deficit	☐	☐
Depression	☐	☐
Diarrhoea	☐	☐
Dizziness	☐	☐
Dyspepsia	☐	☐
Dyspnoea	☐	☐
Erythema	☐	☐
Fibromyalgia symptoms	☐	☐
Gastric pyrosis (heartburn)	☐	☐
Gastro-oesophageal reflux	☐	☐
Hyperosmia	☐	☐
Hyporexia (Decreased appetite)	☐	☐
Light-headedness	☐	☐
Meteorism (tympanites)	☐	☐
Motor incoordination	☐	☐
Nausea	☐	☐
Palpitation	☐	☐
Paraesthesia	☐	☐
Pressure peaks	☐	☐
Pruritus (itch)	☐	☐
Rash	☐	☐
Recurrent fever	☐	☐
Sense of confusion	☐	☐
Sense of suffocation/choking	☐	☐
Sleep disturbance	☐	☐
Tachypnoea	☐	☐
Trembling	☐	☐
Vomiting	☐	☐
Working memory deficit	☐	☐

ENVIRONMENTAL ASSESSMENT

EXISTING PROPERTY INFORMATION:

This section of the Environmental Assessment is for information regarding the existing property only.

Your application is complete when all attached supplemental applications are completed and submitted. The case manager will notify you if any additional items or reviews are necessary.

Assessor Parcel Number(s): _____

Square Footage of Property: _____ **Average slope of land if over 15%** _____

Surrounding Land Uses:

North: _____ **East:** _____

South: _____ **West:** _____

EXISTING BUILDING(S)	BUILDING A	BUILDING B	BUILDING C	BUILDING D
Total gross square footage				
Total commercial gross square footage				
Total residential gross square footage				
Year built				
Building footprint in square feet				
Open space / landscaping square footage				
Paving square footage				
Number of parking spaces				
Height of building in feet				
Number of stories				
Number of housing units				
Square feet to be demolished				
Number of covenanted affordable units to be demolished				
Number of housing units to be demolished				
Number of hotel / motel rooms to be demolished				
To be altered? (yes / no)				
To be relocated? (yes / no)				
Un reinforced masonry? (yes / no)				
Type of use (i.e. residential, commercial, mixed uses, etc.)				

ADDRESS OF LOCATIONS OF EXISTING BUILDINGS:

Building A: _____

Building B: _____

Building C: _____

Building D: _____

Environment Quality Survey						
Street Name:						
Date and day:						**Time:**
Weather:						
Tick the boxes below which best match the description of the environment:						
	1	2	3	4	5	
Quality of buildings poor						Excellent condition
Lots of traffic and parked cars						Little traffic / few cars
Derelict/vandalised						Well kept area
Lots of litter						Clean tidy area
No greenery/landscaping						Greenery/landscaping
Noisy						Quiet
Pavement/road in poor condition						Pavement, road in good condition
Lack of street lighting						Street is well lit
Total score for this street out of 40:						
Important: How to score quality of buildings:						
5 = Immaculate paintwork/windows/brickwork. Building material show style and thought. Design is interesting. Evidence of improvement/excellent maintenance.Aesthetically pleasing.						
3 = average paintwork/windows/brickwork. Building materials/style is functional. Design is basic. No evidence of improvement or maintenance. Buildings however do not spoil the area.						
1 = poor paintwork/windows/brickwork. Unatttractive building materials and style. Unattractive design. Buildings in state of disrepair. An eyesore.						

PHYSICAL SYMPTOMS (PHQ-15)

During the past 4 weeks, how much have you been bothered by any of the following problems?

Somatization	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods ***WOMEN ONLY***	☐	☐	☐
e. Headaches	☐	☐	☐
f. Chest pain	☐	☐	☐
g. Dizziness	☐	☐	☐
h. Fainting spells	☐	☐	☐
i. Feeling your heart pound or race	☐	☐	☐
j. Shortness of breath	☐	☐	☐
k. Pain or problems during sexual intercourse	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐
n. Feeling tired or having low energy	☐	☐	☐
o. Trouble sleeping	☐	☐	☐

(*For office coding: Total Score T*_____ = _____ + _____)

Patient Health Questionnaire 15-Item Somatic Symptom Severity Scale (PHQ-15)

The PHQ-15 is a somatic symptom subscale derived from the full Patient Health Questionnaire (PHQ) which is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-15 comprises 15 somatic symptoms from the PHQ, each symptom scored from 0 ("not bothered at all") to 2 ("bothered a lot"). Patients are asked to rate the severity of each symptom as:

- 0 ("not bothered at all"),
- 1 ("bothered a little"), or
- 2 ("bothered a lot").

The PHQ-15 is intended to function as a continuous measure of somatic symptom severity. The PHQ-15 score is divided into several categories to illustrate more clearly the relationship between graded increases in somatic symptom severity and various health outcomes.

Levels of Somatic Symptom Severity	PHQ-15 Score
Minimal	0-4
Low	5-9
Medium	10-14
High	15-30

Sleep Apnea Questionnaire

Name: _____ ❑ Male ❑ Female

Age: _____ Height _____ Weight _____

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 - 2

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?
Use the following scale to choose the most appropriate number:

0 no chance	1 slight chance	2 moderate chance	3 high chance

Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive, in a public space	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
As a passenger in car for an hour without a break	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3

Total Score:

Mental Health Continuum Self-Check

	Healthy	Reacting	Injured	Ill
Changes in Mood	Normal mood fluctuations Calm Confident	Irritable Impatient Nervous Sadness	Angry Anxious Pervasive sadness	Easily enraged Excessive anxiety/panic Depressed mood, numb
Changes in Thinking and Attitude	Good sense of humor Takes things in stride Ability to concentrate and focus on tasks	Displaced sarcasm Intrusive thoughts Sometimes distracted or loss of focus on tasks	Negative attitude Recurrent intrusive thoughts Constantly distracted or cannot focus on tasks	Noncompliant Suicidal thoughts/intent Inability to concentrate, loss of memory or cognitive abilities
Changes in Behaviour and Performance	Physically and socially active Present Performing well	Decreased activity/socializing Present but distracted Procrastination	Avoidance Tardiness Decreased performance	Withdrawal Absenteeism Can't perform duties/tasks
Physical Changes	Normal sleep patterns Good appetite Feeling energetic Maintaining a stable weight	Trouble sleeping Changes in eating patterns Some lack of energy Some weight gain or loss	Restless sleep Loss of appetite Some tiredness or fatigue Fluctuations or changes in weight	Cannot fall/stay asleep No appetite Constant and prolonged fatigue or exhaustion Extreme weight gain or loss
Changes in Addictive Behaviours	Limited alcohol consumption, no binge drinking Limited/no addictive behaviours No trouble/impact due to substance use	Regular to frequent alcohol consumption, limited binge drinking Some to regular addictive behaviours Limited to some trouble/impact due to substance use	Frequent alcohol consumption, binge drinking Struggle to control addictive behaviours Increasing trouble/impact due to substance use	Regular to frequent binge drinking Addiction Significant trouble/impact due to substance use

Brief Psychiatric Rating Scale (BPRS)

Patient Name _____ Today's Date _____

Please enter the score for the term that best describes the patient's condition.

0 = Not assessed, 1 = Not present, 2 = Very mild, 3 = Mild, 4 = Moderate, 5 = Moderately severe, 6 = Severe, 7 = Extremely severe

Score		
☐	1.	**SOMATIC CONCERN** Preoccupation with physical health, fear of physical illness, hypochondriasis.
☐	2.	**ANXIETY** Worry, fear, over-concern for present or future, uneasiness.
☐	3.	**EMOTIONAL WITHDRAWAL** Lack of spontaneous interaction, isolation deficiency in relating to others.
☐	4.	**CONCEPTUAL DISORGANIZATION** Thought processes confused, disconnected, disorganized, disrupted.
☐	5.	**GUILT FEELINGS** Self-blame, shame, remorse for past behavior.
☐	6.	**TENSION** Physical and motor manifestations of nervousness, over-activation.
☐	7.	**MANNERISMS AND POSTURING** Peculiar, bizarre, unnatural motor behavior (not including tic).
☐	8.	**GRANDIOSITY** Exaggerated self-opinion, arrogance, conviction of unusual power or abilities.
☐	9.	**DEPRESSIVE MOOD** Sorrow, sadness, despondency, pessimism.
☐	10.	**HOSTILITY** Animosity, contempt, belligerence, disdain for others.
☐	11.	**SUSPICIOUSNESS** Mistrust, belief others harbor malicious or discriminatory intent.
☐	12.	**HALLUCINATORY BEHAVIOR** Perceptions without normal external stimulus correspondence.
☐	13.	**MOTOR RETARDATION** Slowed, weakened movements or speech, reduced body tone.
☐	14.	**UNCOOPERATIVENESS** Resistance, guardedness, rejection of authority.
☐	15.	**UNUSUAL THOUGHT CONTENT** Unusual, odd, strange, bizarre thought content.
☐	16.	**BLUNTED AFFECT** Reduced emotional tone, reduction in formal intensity of feelings, flatness.
☐	17.	**EXCITEMENT** Heightened emotional tone, agitation, increased reactivity.
☐	18.	**DISORIENTATION** Confusion or lack of proper association for person, place or time.

ADHD Adult Self-Report Scale Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, circle the correct number that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often	Score
1. How often do you make careless mistakes when you have to work on a boring or difficult project?	0	1	2	3	4	
2. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	0	1	2	3	4	
3. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	0	1	2	3	4	
4. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	0	1	2	3	4	
5. How often do you have difficulty getting things in order when you have to do a task that requires organization?	0	1	2	3	4	
6. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	0	1	2	3	4	
7. How often do you misplace or have difficulty finding things at home or at work?	0	1	2	3	4	
8. How often are you distracted by activity or noise around you?	0	1	2	3	4	
9. How often do you have problems remembering appointments or obligations?	0	1	2	3	4	
					Part A – Total	
10. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	0	1	2	3	4	
11. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	0	1	2	3	4	
12. How often do you feel restless or fidgety?	0	1	2	3	4	
13. How often do you have difficulty unwinding and relaxing when you have time to yourself?	0	1	2	3	4	
14. How often do you feel overly active and compelled to do things, like you were driven by a motor?	0	1	2	3	4	
15. How often do you find yourself talking too much when you are in social situations?	0	1	2	3	4	
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	0	1	2	3	4	
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	0	1	2	3	4	
18. How often do you interrupt others when they are busy?	0	1	2	3	4	
					Part B – Total	

Adult ADHD Self-Report Scale (ASRS)
Symptom Checklist Instructions

The questions on the tear pad below are designed to stimulate dialogue between you and your patients and to help confirm if they may be suffering from the symptoms of attention-deficit/hyperactivity disorder (ADHD). Physicians should consider using Symptom Checklist for patients whom they have reason to believe might have ADHD. This could be based on results of a screening instrument or if the patient presents with symptoms that may be consistent with ADHD.

1. Provide the symptom checklist to patient.

Tear one sheet from the pad, and ask the patient to complete it prior to the exam.

2. Assess the patient's symptoms, impairments, and history.

Score*	Evaluation
0-16	Unlikely to have ADHD
17-23	Likely to have ADHD
24 or greater	Highly likely to have ADHD

*either Part A or Part B

Assess symptoms

- Add the patient's score for Part A (Inattentive)
- Add the patient's score for Part B (Hyperactive/Impulsive)
- If the score is in the likely or highly likely category for **either Part A or Part B**, the patient has symptoms consistent with ADHD and a more thorough clinical evaluation to understand impairments and history is warranted.
- If the score is in the unlikely category for **either Part A or Part B**, but you still suspect ADHD, consider evaluating them for impairments based on the symptoms present. Sometimes adults with ADHD suffer significant impairment due to only a few symptoms.
- An adult with ADHD may have symptoms that manifest quite differently when compared with a child. The ASRS checklist reflects the adult manifestation of ADHD symptoms.

Assess impairments

Review the checklist with your patients and evaluate any impairments in the work/school, social, and family settings.

Symptom frequency is often associated with symptom severity, and, therefore, the ASRS checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how this problem has affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other. This discussion will provide details about the extent of the impairments.

Assess history

Consider assessing the presence of these symptoms or similar symptoms in childhood. Adults who have ADHD need not have been formally diagnosed in childhood. In evaluating a patient's history, look for evidence of early-appearing and long-standing problems with attention or self-control. Some significant symptoms should have been present in childhood, but full symptomology is not necessary.

Request to see school report cards. But remember, many adults attended school at a time when ADHD and its symptoms were not commonly identified. Consider more than grades alone; often, written comments on the report card are of the most value. If report cards are not available, you might ask questions such as, "If I were a teacher, how would I describe you in class?" and "If I looked at your grade school report card, what would I read?"

3. Keep the symptom checklist in the patient's file for future reference.

PTSD Screen

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example, a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, or having a loved one die through homicide or suicide.

Have you ever experienced this kind of event? ☐ Yes ☐ No

If yes, please answer the questions below. **In the past month, have you:**

- ☐ Had nightmares about the event(s) or thought about the event(s) when you didn't want to?
- ☐ Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
- ☐ Been constantly on guard, watchful, or easily startled?
- ☐ Felt numb or detached from people, activities, or your surroundings?
- ☐ Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

If you answered "yes" to 3 or more of these questions, talk to a mental health care provider to learn more about PTSD and PTSD treatment.

Answering "yes" to 3 or more questions does not mean you have PTSD. Only a mental health care provider can tell you for sure.

Body Sensations Questionnaire

Client ID ..... Date .....

Below is a list of specific body sensations that may occur when you are nervous or in a feared situation. Please mark down how afraid you are of these feelings. Use the following five point scale:

1	2	3	4	5
not at all	somewhat	moderately	very	extremely

.....frightened by this sensation.

Please rate all items.

1. heart palpitations	1	2	3	4	5
2. pressure or a heavy feeling in chest	1	2	3	4	5
3. numbness in arms or legs	1	2	3	4	5
4. tingling in the fingertips	1	2	3	4	5
5. numbness in another part of your body	1	2	3	4	5
6. feeling short of breath	1	2	3	4	5
7. dizziness	1	2	3	4	5
8. blurred or distorted vision	1	2	3	4	5
9. nausea	1	2	3	4	5
10. having "butterflies" in your stomach	1	2	3	4	5
11. feeling a knot in your stomach	1	2	3	4	5
12. having a lump in your throat	1	2	3	4	5
13. wobbly or rubber legs	1	2	3	4	5
14. sweating	1	2	3	4	5
15. a dry throat	1	2	3	4	5
16. feeling disoriented and confused	1	2	3	4	5
17. feeling disconnected from your body: only partly present	1	2	3	4	5
18. other (please describe)	1	2	3	4	5
.....	1	2	3	4	5
.....	1	2	3	4	5

Generalized Anxiety Disorder 7- Item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

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

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

GENERAL ANXIETY DISORDER 7 ITEM SCALE (GAD-7)

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

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

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

GAD-7 SCORING and CLASSIFICATION

The GAD-7 is scored by adding the scores for all 7 items, giving a total score from 0 to 21.

The total GAD-7 score is classified as follows:

0 to 4 Minimal anxiety symptoms
5 to 10 Mild anxiety symptoms
10 to 14 Moderate anxiety symptoms
15 to 21 Severe anxiety symptoms

REFERENCE

Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Internal Medicine 2006 166:1092-1097.

Additional resources and information regarding the GAD-7 is also available at the https://www.phqscreeners.com website.

Circle "yes" or "no" for each question.
1. Do you think there is something seriously wrong with your body?
Yes
No
2. Do you worry a lot about your health?
Yes
No
3. Is it hard for you to believe the doctor when he tells you there is nothing to worry about?
Yes
No
4. Do you often worry about the possibility that you have a serious illness?
Yes
No
5. Are you bothered by many different pains or aches?
Yes
No
6. If a disease is brought to your attention (eg, on TV, radio, the newspapers, or by someone you know), do you worry about getting it yourself?
Yes
No
7. Do you find that you are bothered by many different symptoms?
Yes
No

Adapted from: Fink P, Ewald H, Jensen J, et al. Screening for somatization and hypochondriasis in primary care and neurological in-patients: a seven-item scale for hypochondriasis and somatization. J Psychosom Res 1999; 46:261.

SCOFF Questionnaire

(Useful Eating Disorder screening questions)

The **SCOFF** Questionnaire is a five-question screening tool designed to clarify suspicion that an eating disorder might exist rather than to make a diagnosis. The questions can be delivered either verbally or in written form.

S – Do you make yourself **S**ick because you feel uncomfortably full?

C – Do you worry you have lost **C**ontrol over how much you eat?

O – Have you recently lost more than **O**ne stone (6.35 kg) in a three-month period?

F – Do you believe yourself to be **F**at when others say you are too thin?

F – Would you say **F**ood dominates your life?

An answer of 'yes' to two or more questions warrants further questioning and more comprehensive assessment

A further two questions have been shown to indicate a high sensitivity and specificity for bulimia nervosa. These questions indicate a need for further questioning and discussion.

1. Are you satisfied with your eating patterns?
2. Do you ever eat in secret?

Luck, A.J., Morgan, J.F., Reid, F., O'Brien, A., Brunton, J., Price, C., Perry, L., Lacey, J.H. (2002), 'The SCOFF questionnaire and clinical interview for eating disorders in general practice: comparative study', *British Medical Journal*, 325,7367, 755 - 756.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Zung Self-Rating Depression Scale

Patient's Initials

Date of Assessment

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

Make check mark (✓) in appropriate column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

Adapted from Zung, A self-rating depression scale, *Arch Gen Psychiatry*, 1965;12:63-70.

KEY TO SCORING THE ZUNG SELF-RATING DEPRESSION SCALE

Consult this key for the value (1-4) that correlates with patients' responses to each statement. Add up the numbers for a total score. Most people with depression score between 50 and 69. The highest possible score is 80[1].

Make check mark (✓) in appropriate column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue	**1**	**2**	**3**	**4**
2. Morning is when I feel the best	**4**	**3**	**2**	**1**
3. I have crying spells or feel like it	**1**	**2**	**3**	**4**
4. I have trouble sleeping at night	**1**	**2**	**3**	**4**
5. I eat as much as I used to	**4**	**3**	**2**	**1**
6. I still enjoy sex	**4**	**3**	**2**	**1**
7. I notice that I am losing weight	**1**	**2**	**3**	**4**
8. I have trouble with constipation	**1**	**2**	**3**	**4**
9. My heart beats faster than usual	**1**	**2**	**3**	**4**
10. I get tired for no reason	**1**	**2**	**3**	**4**
11. My mind is as clear as it used to be	**4**	**3**	**2**	**1**
12. I find it easy to do the things I used to	**4**	**3**	**2**	**1**
13. I am restless and can't keep still	**1**	**2**	**3**	**4**
14. I feel hopeful about the future	**4**	**3**	**2**	**1**
15. I am more irritable than usual	**1**	**2**	**3**	**4**
16. I find it easy to make decisions	**4**	**3**	**2**	**1**
17. I feel that I am useful and needed	**4**	**3**	**2**	**1**
18. My life is pretty full	**4**	**3**	**2**	**1**
19. I feel that others would be better off if I were dead	**1**	**2**	**3**	**4**
20. I still enjoy the things I used to do	**4**	**3**	**2**	**1**

Adapted from Zung.[2]

References: 1. Carroll BJ, Fielding JM, Blashki TG. Depression rating scales: a critical review. *Arch Gen Psychiatry.* 1973; 28:361-366.
2. Zung WWK. A self-rating depression scale. *Arch Gen Psychiatry*. 1965;12:63-70.

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Research Triangle Park, NC 27709
Web site: www.glaxowellcome.com

 Printed in USA. WEL365R0 July 1997

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name _____ Today's Date _____

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, calculate the patient's score on the first 17 answers.

☐ 1. DEPRESSED MOOD
(Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
0 = Absent
1 = Sadness, etc.
2 = Occasional weeping
3 = Frequent weeping
4 = Extreme symptoms

☐ 2. FEELINGS OF GUILT
0 = Absent
1 = Self-reproach, feels he/she has let people down
2 = Ideas of guilt
3 = Present illness is a punishment; delusions of guilt
4 = Hallucinations of guilt

☐ 3. SUICIDE
0 = Absent
1 = Feels life is not worth living
2 = Wishes he/she were dead
3 = Suicidal ideas or gestures
4 = Attempts at suicide

☐ 4. INSOMNIA - Initial
(Difficulty in falling asleep)
0 = Absent
1 = Occasional
2 = Frequent

☐ 5. INSOMNIA - Middle
(Complains of being restless and disturbed during the night. Waking during the night.)
0 = Absent
1 = Occasional
2 = Frequent

☐ 6. INSOMNIA - Delayed
(Waking in early hours of the morning and unable to fall asleep again)
0 = Absent
1 = Occasional
2 = Frequent

☐ 7. WORK AND INTERESTS
0 = No difficulty
1 = Feelings of incapacity, listlessness, indecision and vacillation
2 = Loss of interest in hobbies, decreased social activities
3 = Productivity decreased
4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

☐ 8. RETARDATION
(Slowness of thought, speech, and activity; apathy; stupor.)
0 = Absent
1 = Slight retardation at interview
2 = Obvious retardation at interview
3 = Interview difficult
4 = Complete stupor

☐ 9. AGITATION
(Restlessness associated with anxiety.)
0 = Absent
1 = Occasional
2 = Frequent

☐ 10. ANXIETY - PSYCHIC
0 = No difficulty
1 = Tension and irritability
2 = Worrying about minor matters
3 = Apprehensive attitude
4 = Fears

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

☐ 11. ANXIETY - SOMATIC

Gastrointestinal, indigestion
Cardiovascular, palpitation, Headaches
Respiratory, Genito-urinary, etc.

0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

☐ 12. SOMATIC SYMPTOMS - GASTROINTESTINAL

(Loss of appetite , heavy feeling in abdomen; constipation)

0 = Absent
1 = Mild
2 = Severe

☐ 13. SOMATIC SYMPTOMS - GENERAL

(Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)

0 = Absent
1 = Mild
2 = Severe

☐ 14. GENITAL SYMPTOMS

(Loss of libido, menstrual disturbances)

0 = Absent
1 = Mild
2 = Severe

☐ 15. HYPOCHONDRIASIS

0 = Not present
1 = Self-absorption (bodily)
2 = Preoccupation with health
3 = Querulous attitude
4 = Hypochondriacal delusions

☐ 16. WEIGHT LOSS

0 = No weight loss
1 = Slight
2 = Obvious or severe

☐ 17. INSIGHT

(Insight must be interpreted in terms of patient's understanding and background.)

0 = No loss
1 = Partial or doubtfull loss
2 = Loss of insight

TOTAL ITEMS 1 TO 17: _____

0 - 7 = Normal
8 - 13 = Mild Depression
14-18 = Moderate Depression
19 - 22 = Severe Depression
≥ 23 = Very Severe Depression

☐ 18. DIURNAL VARIATION

(Symptoms worse in morning or evening. Note which it is.)

0 = No variation
1 = Mild variation; AM ( ) PM ( )
2 = Severe variation; AM ( ) PM ( )

☐ 19. DEPERSONALIZATION AND DEREALIZATION

(feelings of unreality, nihilistic ideas)

0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

☐ 20. PARANOID SYMPTOMS

(Not with a depressive quality)

0 = None
1 = Suspicious
2 = Ideas of reference
3 = Delusions of reference and persecution
4 = Hallucinations, persecutory

☐ 21. OBSESSIONAL SYMPTOMS

(Obsessive thoughts and compulsions against which the patient struggles)

0 = Absent
1 = Mild
2 = Severe

---

* Adapted from Hamilton, M. *Journal of Neurology, Neurosurgery, and Psychiatry*. 23:56-62, 1960.

Edinburgh Postnatal Depression Scale (EPDS)

Patient Label

Mother's OB or Doctor's Name:

Doctor's Phone #: _____

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK** (✔) on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—*not just how you feel today.* Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, *call your health care provider regardless of your score.*

Below is an example already completed.

I have felt happy:
Yes, all of the time ____ (0)
Yes, most of the time ✔ (1)
No, not very often ____ (2)
No, not at all ____ (3)

This would mean: "I have felt happy most of the time" in the past week. Please complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things:
   As much as I always could ____ (0)
   Not quite so much now ____ (1)
   Definitely not so much now ____ (2)
   Not at all ____ (3)

2. I have looked forward with enjoyment to things:
   As much as I ever did ____ (0)
   Rather less than I used to ____ (1)
   Definitely less than I used to ____ (2)
   Hardly at all ____ (3)

3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time ____ (3)
   Yes, some of the time ____ (2)
   Not very often ____ (1)
   No, never ____ (0)

4. I have been anxious or worried for no good reason:
   No, not at all ____ (0)
   Hardly ever ____ (1)
   Yes, sometimes ____ (2)
   Yes, very often ____ (3)

5. I have felt scared or panicky for no good reason:
   Yes, quite a lot ____ (3)
   Yes, sometimes ____ (2)
   No, not much ____ (1)
   No, not at all ____ (0)

6. Things have been getting to me:
   Yes, most of the time I haven't been able to cope at all ____ (3)
   Yes, sometimes I haven't been coping as well as usual ____ (2)
   No, most of the time I have coped quite well ____ (1)
   No, I have been coping as well as ever ____ (0)

7. I have been so unhappy that I have had difficulty sleeping:
   Yes, most of the time ____ (3)
   Yes, sometimes ____ (2)
   No, not very often ____ (1)
   No, not at all ____ (0)

8. I have felt sad or miserable:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Not very often ____ (1)
   No, not at all ____ (0)

9. I have been so unhappy that I have been crying:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Only occasionally ____ (1)
   No, never ____ (0)

10. The thought of harming myself has occurred to me:*
    Yes, quite often ____ (3)
    Sometimes ____ (2)
    Hardly ever ____ (1)
    Never ____ (0)

TOTAL YOUR SCORE HERE ▶

Thank you for completing this survey. Your doctor will score this survey and discuss the results with you.

Verbal consent to contact above mentioned MD witnessed by:

_____

Edinburgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky.

Edinburgh Postnatal Depression Scale (EPDS) Scoring & Other Information

ABOUT THE EPDS

Studies show that postpartum depression (PPD) affects at least 10 percent of women and that many depressed mothers do not get proper treatment. These mothers might cope with their baby and with household tasks, but their enjoyment of life is seriously affected, and it is possible that there are long term effects on the family.

The Edinburgh Postnatal Depression Scale (EPDS) was developed to assist health professionals in detecting mothers suffering from PPD; a distressing disorder more prolonged than the "blues" (which can occur in the first week after delivery).

The scale consists of 10 short statements. A mother checks off one of four possible answers that is closest to how she has felt during the past week. Most mothers easily complete the scale in less than five minutes.

Responses are scored 0, 1, 2 and 3 based on the seriousness of the symptom. Items 3, 5 to 10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is found by adding together the scores for each of the 10 items.

Mothers scoring above 12 or 13 are likely to be suffering from depression and should seek medical attention. A careful clinical evaluation by a health care professional is needed to confirm a diagnosis and establish a treatment plan. The scale indicates how the mother felt during the previous week, and it may be useful to repeat the scale after two weeks.

INSTRUCTIONS FOR USERS

1. The mother checks off the response that comes closest to how she has felt during the previous seven days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or reading difficulties.
5. The scale can be used at six to eight weeks after birth or during pregnancy.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* 150, 782-786. The Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245, e-mail: mikeohara@uiowa.edu.

Escala Edinburgh para la Depresión Postnatal (Spanish Version)

Patient Label	OB de la madre o el nombre del médico Número de teléfono del médico

Como usted está embarazada o hace poco que tuvo un bebé, nos gustaría saber como se siente actualmente. Por favor MARQUE (√) la respuesta que más se acerca a como se ha sentido durante LOS ÚLTIMOS 7 DÍAS y no sólo como se ha sentido hoy.

A continuación se muestra un ejemplo completado:

Me he sentido feliz:
Sí, todo el tiempo ____ 0
Sí, la mayor parte del tiempo ___✔ 1
No, no muy a menudo ____ 2
No, en absoluto ____ 3

Esto significa: "Me he sentido feliz la mayor parte del tiempo" durante la última semana. Por favor complete las otras preguntas de la misma manera.

1. He podido reír y ver el lado bueno de las cosas:
   Tanto como siempre he podido hacerlo ____ 0
   No tanto ahora ____ 1
   Sin duda, mucho menos ahora ____ 2
   No, en absoluto ____ 3

2. He mirado al futuro con placer para hacer cosas:
   Tanto como siempre ____ 0
   Algo menos de lo que solía hacerlo ____ 1
   Definitivamente menos de lo que solía hacerlo ____ 2
   Prácticamente nunca ____ 3

3. Me he culpado sin necesidad cuando las cosas marchaban mal:
   Sí, casi siempre ____ 3
   Sí, algunas veces ____ 2
   No muy a menudo ____ 1
   No, nunca ____ 0

4. He estado ansiosa y preocupada sin motivo alguno:
   No, en absoluto ____ 0
   Casi nada ____ 1
   Sí, a veces ____ 2
   Sí, muy a menudo ____ 3

5. He sentido miedo o pánico sin motivo alguno:
   Sí, bastante ____ 3
   Sí, a veces ____ 2
   No, no mucho ____ 1
   No, en absoluto ____ 0

6. Las cosas me oprimen o agobian:
   Sí, la mayor parte del tiempo no he podido sobrellevarlas ____ 3
   Sí, a veces no he podido sobrellevarlas de la manera ____ 2
   No, la mayoría de las veces he podido sobrellevarlas bastante bien ____ 1
   No, he podido sobrellevarlas tan bien como lo hecho siempre ____ 0

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:
   Sí, casi siempre ____ 3
   Sí, a veces ____ 2
   No muy a menudo ____ 1
   No, en absoluto ____ 0

8. Me he sentido triste y desgraciada:
   Sí, casi siempre ____ 3
   Sí, bastante a menudo ____ 2
   No muy a menudo ____ 1
   No, en absoluto ____ 0

9. Me he sentido tan infeliz que he estado llorando:
   Sí, casi siempre ____ 3
   Sí, bastante a menudo ____ 2
   Ocasionalmente ____ 1
   No, nunca ____ 0

10. He pensado en hacerme daño:
    Sí, bastante a menudo ____ 3
    A veces ____ 2
    Casi nunca ____ 1
    No, nunca ____ 0

Total Score: _____

Consentimiento verbal para contacto arriba mencionado MD presenciada por:

_____

Edinburgh Postnatal Depression Scale (EPDS). Texto adaptado del *British Journal of Psychiatry,* Junio, 1987, vol. 150 por J.L. Cox, J.M. Holden, R. Segovsky.

Edinburgh Postnatal Depression Scale (EPDS) Scoring & Other Information

ABOUT THE EPDS

Response categories are scored 0, 1, 2 and 3 according to increased severity of the symptom. Items 3, 5-10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Users may reproduce the scale without further permission providing they respect copyright (which remains with the *British Journal of Psychiatry*) quoting the names of the authors, the title and the source of the paper in all reproduced copies.

The Edinburgh Postnatal Depression Scale (EPDS) was developed to assist primary care health professionals in detecting mothers suffering from postpartum depression (PPD); a distressing disorder more prolonged than the "blues" (which occur in the first week after delivery), but less severe than puerperal psychosis.

Previous studies have shown that PPD affects at least 10 percent of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long term effects on the family.

The EPDS was developed at health centers in Livingston and Edinburgh. It consists of 10 short statements. The mother underlines which of the four possible responses is closest to how she has been feeling during the past week. Most mothers complete the scale without difficulty in less than five minutes.

The validation study showed that mothers who scored above a threshold 12/13 were likely to be suffering from a depressive illness of varying severity. Nevertheless, the EPDS score should not override clinical judgement. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother felt during the previous week, and in doubtful cases it may be usefully repeated after two weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

INSTRUCTIONS FOR USERS

1. The mother is asked to underline the response that comes closest to how she has felt during the previous seven days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at six to eight weeks to screen postnatal women or during pregnancy. The child health clinic, postpartum check-up or a home visit may provide suitable opportunities for its completion.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* 150, 782-786. The Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245, e-mail: mikeohara@uiowa.edu.

Geriatric Depression Scale (Short Form)

Patient's Name: _____ Date: _____

Instructions: Choose the best answer for how you felt over the past week. Note: when asking the patient to complete the form, provide the self-rated form (included on the following page).

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / ***NO***	
2.	Have you dropped many of your activities and interests?	***YES*** / NO	
3.	Do you feel that your life is empty?	***YES*** / NO	
4.	Do you often get bored?	***YES*** / NO	
5.	Are you in good spirits most of the time?	YES / ***NO***	
6.	Are you afraid that something bad is going to happen to you?	***YES*** / NO	
7.	Do you feel happy most of the time?	YES / ***NO***	
8.	Do you often feel helpless?	***YES*** / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	***YES*** / NO	
10.	Do you feel you have more problems with memory than most people?	***YES*** / NO	
11.	Do you think it is wonderful to be alive?	YES / ***NO***	
12.	Do you feel pretty worthless the way you are now?	***YES*** / NO	
13.	Do you feel full of energy?	YES / ***NO***	
14.	Do you feel that your situation is hopeless?	***YES*** / NO	
15.	Do you think that most people are better off than you are?	***YES*** / NO	
		TOTAL	

(Sheikh & Yesavage, 1986)

Scoring:

Answers indicating depression are in bold and italicized; score one point for each one selected. A score of 0 to 5 is normal. A score greater than 5 suggests depression.

Sources:

- Sheikh JI, Yesavage JA. Geriatric Depression Scale (GDS): recent evidence and development of a shorter version. *Clin Gerontol.* 1986 June;5(1/2):165-173.
- Yesavage JA. Geriatric Depression Scale. *Psychopharmacol Bull.* 1988;24(4):709-711.
- Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. *J Psychiatr Res.* 1982-83;17(1):37-49.

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Since Last Visit**	
Ask questions that are bold and <u>underlined</u>	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***<u>Have you actually had any thoughts of killing yourself?</u>***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***<u>Have you been thinking about how you might kill yourself?</u>***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u>, as opposed to "*I have the thoughts but I definitely will not do anything about them*." ***<u>Have you had these thoughts and had some intention of acting on them?</u>***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***<u>Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?</u>***		
6) Suicide Behavior ***<u>Have you done anything, started to do anything, or prepared to do anything to end your life?</u>*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

Fear-Avoidance Beliefs Questionnaire

Here are some of the things which other patients have told us about their pain. For each statement please circle any number from 0 to 6 to say how much physical activities, such as, bending, lifting, walking or driving affect or would affect *your* back pain.

		COMPLETELY DISAGREE			UNSURE			COMPLETELY AGREE
1	My pain was caused by physical activity.....	0	1	2	3	4	5	6
2	Physical activity makes my pain worse.....	0	1	2	3	4	5	6
3	Physical activity might harm my back	0	1	2	3	4	5	6
4	I should not do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
5	I cannot do physical activities which (might) make my pain worse	0	1	2	3	4	5	6

The following statements are about how your normal work affects or would affect your back pain.

		COMPLETELY DISAGREE			UNSURE			COMPLETELY AGREE
6	My pain was caused by my work or by an accident at work	0	1	2	3	4	5	6
7	My work aggravated my pain.....	0	1	2	3	4	5	6
8	I have a claim for compensation for my pain	0	1	2	3	4	5	6
9	My work is too heavy for me.....	0	1	2	3	4	5	6
10	My work makes or would make my pain worse	0	1	2	3	4	5	6
11	My work might harm my back.....	0	1	2	3	4	5	6
12	I should not do my normal work with my present pain.....	0	1	2	3	4	5	6
13	I cannot do my normal work with my present pain.....	0	1	2	3	4	5	6
14	I cannot do my normal work till my pain is treated.....	0	1	2	3	4	5	6
15	I do not think that I will be back to my normal work within 3 months	0	1	2	3	4	5	6
16	I do not think that I will ever be able to go back to that work	0	1	2	3	4	5	6

Scoring:

Scale 1: fear-avoidance beliefs about work—items 6, 7, 9, 10, 11, 12, 15.
Scale 2: fear-avoidance beliefs about physical activity—items 2, 3, 4, 5.

PAIN DISABILITY QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Can not sit/stand at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems — Can not walk/run at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

_____
Examiner

OTHER COMMENTS:

_____

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

American Chronic Pain Association

Quality Of Life Scale

A Measure Of Function For People With Pain

0 Non-functioning	Stay in bed all day Feel hopeless and helpless about life
1	Stay in bed at least half the day Have no contact with outside world
2	Get out of bed but don't get dressed Stay at home all day
3	Get dressed in the morning Minimal activities at home Contact with friends via phone, email
4	Do simple chores around the house Minimal activities outside of home two days a week
5	Struggle but fulfill daily home responsibilities No outside activity Not able to work/volunteer
6	Work/volunteer limited hours Take part in limited social activities on weekends
7	Work/volunteer for a few hours daily. Can be active at least five hours a day. Can make plans to do simple activities on weekends
8	Work/volunteer for at least six hours daily Have energy to make plans for one evening social activity during the week Active on weekends
9	Work/volunteer/be active eight hours daily Take part in family life Outside social activities limited
10 Normal Quality of Life	Go to work/volunteer each day Normal daily activities each day Have a social life outside of work Take an active part in family life

Barthel Index of Activities of Daily Living

Instructions: Choose the scoring point for the statement that most closely corresponds to the patient's current level of ability for each of the following 10 items. Record actual, not potential, functioning. Information can be obtained from the patient's self-report, from a separate party who is familiar with the patient's abilities (such as a relative), or from observation. Refer to the Guidelines section on the following page for detailed information on scoring and interpretation.

The Barthel Index

Bowels
0 = incontinent (or needs to be given enemata)
1 = occasional accident (once/week)
2 = continent
Patient's Score: _____

Bladder
0 = incontinent, or catheterized and unable to manage
1 = occasional accident (max. once per 24 hours)
2 = continent (for over 7 days)
Patient's Score: _____

Grooming
0 = needs help with personal care
1 = independent face/hair/teeth/shaving (implements provided)
Patient's Score: _____

Toilet use
0 = dependent
1 = needs some help, but can do something alone
2 = independent (on and off, dressing, wiping)
Patient's Score: _____

Feeding
0 = unable
1 = needs help cutting, spreading butter, etc.
2 = independent (food provided within reach)
Patient's Score: _____

Transfer
0 = unable – no sitting balance
1 = major help (one or two people, physical), can sit
2 = minor help (verbal or physical)
3 = independent
Patient's Score: _____

Mobility
0 = immobile
1 = wheelchair independent, including corners, etc.
2 = walks with help of one person (verbal or physical)
3 = independent (but may use any aid, e.g., stick)
Patient's Score: _____

Dressing
0 = dependent
1 = needs help, but can do about half unaided
2 = independent (including buttons, zips, laces, etc.)
Patient's Score: _____

Stairs
0 = unable
1 = needs help (verbal, physical, carrying aid)
2 = independent up and down
Patient's Score: _____

Bathing
0 = dependent
1 = independent (or in shower)
Patient's Score: _____

Total Score: _____

(Collin et al., 1988)

Scoring:

Sum the patient's scores for each item. Total possible scores range from 0 – 20, with lower scores indicating increased disability. If used to measure improvement after rehabilitation, changes of more than two points in the total score reflect a probable genuine change, and change on one item from fully dependent to independent is also likely to be reliable.

Sources:

- Collin C, Wade DT, Davies S, Horne V. The Barthel ADL Index: a reliability study. *Int Disabil Stud*. 1988;10(2):61-63.
- Mahoney FI, Barthel DW. Functional evaluation: the Barthel Index. *Md State Med J*. 1965;14:61-65.
- Wade DT, Collin C. The Barthel ADL Index: a standard measure of physical disability? *Int Disabil Stud*. 1988;10(2):64-67.

Guidelines for the Barthel Index of Activities of Daily Living

General

- The Index should be used as a record of what a patient ***does***, NOT as a record of what a patient ***could do***.
- The main aim is to establish degree of independence from any help, physical or verbal, however minor and for whatever reason.
- The need for supervision renders the patient not independent.
- A patient's performance should be established using the best available evidence. Asking the patient, friends/relatives, and nurses will be the usual source, but direct observation and common sense are also important. However, direct testing is not needed.
- Usually the performance over the preceding 24 – 48 hours is important, but occasionally longer periods will be relevant.
- Unconscious patients should score '0' throughout, even if not yet incontinent.
- Middle categories imply that the patient supplies over 50% of the effort.
- Use of aids to be independent is allowed.

Bowels (preceding week)

- If needs enema from nurse, then 'incontinent.'
- 'Occasional' = once a week.

Bladder (preceding week)

- 'Occasional' = less than once a day.
- A catheterized patient who can completely manage the catheter alone is registered as 'continent.'

Grooming (preceding 24 – 48 hours)

- Refers to personal hygiene: doing teeth, fitting false teeth, doing hair, shaving, washing face. Implements can be provided by helper.

Toilet use

- Should be able to reach toilet/commode, undress sufficiently, clean self, dress, and leave.
- 'With help' = can wipe self and do some other of above.

Feeding

- Able to eat any normal food (not only soft food). Food cooked and served by others, but not cut up.
- 'Help' = food cut up, patient feeds self.

Transfer

- From bed to chair and back.
- 'Dependent' = NO sitting balance (unable to sit); two people to lift.
- 'Major help' = one strong/skilled, or two normal people. Can sit up.
- 'Minor help' = one person easily, OR needs any supervision for safety.

Mobility

- Refers to mobility about house or ward, indoors. May use aid. If in wheelchair, must negotiate corners/doors unaided.
- 'Help' = by one untrained person, including supervision/moral support.

Dressing

- Should be able to select and put on all clothes, which may be adapted.
- 'Half' = help with buttons, zips, etc. (*check!*), but can put on some garments alone.

Stairs

- Must carry any walking aid used to be independent.

Bathing

- Usually the most difficult activity.
- Must get in and out unsupervised, and wash self.
- Independent in shower = 'independent' if unsupervised/unaided.

(Collin et al., 1988)

Activities of Daily Living (ADL) Index

Evaluation Form

Name _____ Date _____

For each area of functioning listed below, check the description that applies. (The word "assistance" means supervision, direction, or personal assistance.)

Bathing: Sponge bath, tub bath, or shower.

☐ Receives no assistance (gets into and out of tub by self if tub is the usual means of bathing).

☐ Receives assistance in bathing only one part of the body (such as the back or a leg).

○ Receives assistance in bathing more than one part of the body (or not bathed).

Dressing: Gets clothes from closets and drawers, including underclothes and outer garments, and uses fasteners, including suspenders if worn.

☐ Gets clothes and gets completely dressed without assistance.

☐ Gets clothes and gets dressed without assistance except for tying shoes.

○ Receives assistance in getting clothes or in getting dressed, or stays partly or completely undressed.

Toileting: Goes to the room termed "toilet" for bowel movement/urination, cleans self afterward, and arranges clothes.

☐ Goes to toilet room, cleans self, and arranges clothes without assistance. (May use object for support such as cane, walker, or wheelchair and may manage night bedpan or commode, emptying it in morning.)

○ Receives assistance in going to toilet room or in cleaning self or arranging clothes after elimination or in use of night bedpan or commode.

○ Doesn't go to toilet room for the elimination process.

Transfer

☐ Moves into and out of bed as well as into and out of chair without assistance. (May use object such as cane or walker for support.)

○ Moves into or out of bed or chair with assistance.

○ Doesn't get out of bed.

Continence

☐ Controls urination and bowel movement completely by self.

○ Has occasional accidents.

○ Supervision helps keep control of urination or bowel movement, or catheter is used, or is incontinent.

Feeding

☐ Feeds self without assistance.

☐ Feeds self except for assistance in cutting meat or buttering bread.

○ Receives assistance in feeding or is fed partly or completely through tubes or by IV fluids.

Index

☐ **Indicates independence** ○ **Indicates dependence**

A: Independent in all six functions.

B: Independent in all but one of these functions.

C: Independent in all but bathing and one additional function.

D: Independent in all but bathing, dressing, and one additional function.

E: Independent in all but bathing, dressing, toileting, and one additional function.

F: Independent in all but bathing, dressing, toileting, transferring, and one additional function.

G: Dependent in all six functions.

Other: Dependent in at least two functions but not classifiable as C, D, E, or F.

Adapted with permission from Katz S, Ford A, Moskowitz R, et al: Studies of illness in the aged: The index of ADL—a standardized measure of biological and psychosocial function. *JAMA* 1963;185:914-919.

Activities of Daily Living

Name: _____ **Date:** _____

Activity - Check off	No difficulty	Some difficulty	Cannot perform
Self-care, Personal Hygiene			
Urinating			
Defecating			
Brushing teeth			
Combing hair			
Bathing			
Dressing			
Eating			
Communication			
Writing			
Typing			
Seeing			
Hearing			
Speaking			
Physical Activity			
Standing			
Sitting			
Reclining			
Walking			
Climbing stairs			
Sleep			
Restful pattern			

Activity - Check off	No difficulty	Some difficulty	Cannot perform
Sensory Function			
Hearing			
Seeing			
Feeling / touching			
Tasting			
Smelling			
Nonspecialized Hand Activities			
Grasping			
Lifting			
Discriminating by touch			
Sexual Function			
Orgasm			
Ejaculation			
Lubrication			
Erection			

Adapted from to AMA Guides, 6th Edition

Simple Mental Status

Name _____ Date _____

1. What is the date today? _____

2. What day of the week is it? _____

3. What is the name of this place? _____

4. What is your telephone number?

(If person does not have a telephone: "What is your street address1") _____

5. How old are you? _____

6. When were you born? _____

7. Who is the President of the United States now? _____

8. Who was the President just before that? _____

9. What was your mother'smaiden name? _____

10. Subtract 3 from 20 and keep subtracting 3 from each new number you get, all the way down. _____

_____
Score

For patients with high school education:

0-2 errors = intact mental function
3-4 errors = mild mental impairment
5-7 errors = moderate mental impairment 8-10 errors = severe mental impairment

Allow one more error if the patient has only a grade school education.
Allow one less error if the patient has education beyond high school.

Adapted from Pfeiffer E. *A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. J Am Geriatr Soc* 1975; 23:433-41.

Impairment Level and CDR Clinical Dementia Score [0, 0.5, 1, 2, 3]

	None 0	Questionable 0.5	Mild 1	Moderate 2	Severe 3
Memory	No memory loss or slight inconsistent forgetfulness	Consistent slight forgetfulness; partial recollection of events; "benign" forgetfulness	Moderate memory loss; more marked for recent events; defect interferes with everyday activities	Severe memory loss; only highly learned material retained; new material rapidly lost	Severe memory loss; only fragments remain
Orientation	Fully oriented	Fully oriented except for slight difficulty with time relationships	Moderate difficulty with time relationships; oriented for place at examination; may have geographic disorientation elsewhere	Severe difficulty with time relationships; usually disoriented to time, often to place	Oriented to person only
Judgment & Problem Solving	Solves everyday problems & handles business & financial affairs well; judgment good in relation to past performance	Slight impairment in solving problems, similarities, and differences	Moderate difficulty in handling problems, similarities, and differences; social judgment usually maintained	Severely impaired in handling problems, similarities, and differences; social judgment usually impaired	Unable to make judgments or solve problems

Functional Activities Questionnaire

Administration

Ask informant to rate patient's ability using the following scoring system:

- Dependent = 3
- Requires assistance = 2
- Has difficulty but does by self = 1
- Normal = 0
- Never did [the activity] but could do now = 0
- Never did and would have difficulty now = 1

Writing checks, paying bills, balancing checkbook	
Assembling tax records, business affairs, or papers	
Shopping alone for clothes, household necessities, or groceries	
Playing a game of skill, working on a hobby	
Heating water, making a cup of coffee, turning off stove after use	
Preparing a balanced meal	
Keeping track of current events	
Paying attention to, understanding, discussing TV, book, magazine	
Remembering appointments, family occasions, holidays, medications	
Traveling out of neighborhood, driving, arranging to take buses	
TOTAL SCORE:	

Evaluation

Sum scores (range 0-30). Cutpoint of 9 (dependent in 3 or more activities) is recommended to indicate impaired function and possible cognitive impairment.

Pfeffer RI et al. Measurement of functional activities in older adults in the community. J Gerontol 1982; 37(3):323-329. Reprinted with permission of The Gerontological Society of America, 1030 15th Street NW, Suite 250, Washington, DC 20005 via Copyright Clearance Center, Inc.

Katz Index of Independence in Activities of Daily Living

ACTIVITIES POINTS (1 OR 0)	**INDEPENDENCE:** (1 POINT) **NO** supervision, direction or personal assistance	**DEPENDENCE:** (0 POINTS) **WITH** supervision, direction, personal assistance or total care
BATHING POINTS:	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING POINTS:	**(1 POINT)** Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING POINTS:	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING POINTS:	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE POINTS:	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder.
FEEDING POINTS:	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

Expanded Disability Status Scale (EDSS) – MS

Score	Description
0	Normal neurological exam, no disability in any FS
1.0	No disability, minimal signs in one FS
1.5	No disability, minimal signs in more than one FS
2.0	Minimal disability in one FS
2.5	Mild disability in one FS or minimal disability in two FS
3.0	Moderate disability in one FS, or mild disability in three or four FS. No impairment to walking
3.5	Moderate disability in one FS and more than minimal disability in several others. No impairment to walking
4.0	Significant disability but self-sufficient and up and about some 12 hours a day. Able to walk without aid or rest for 500m
4.5	Significant disability but up and about much of the day, able to work a full day, may otherwise have some limitation of full activity or require minimal assistance. Able to walk without aid or rest for 300m
5.0	Disability severe enough to impair full daily activities and ability to work a full day without special provisions. Able to walk without aid or rest for 200m
5.5	Disability severe enough to preclude full daily activities. Able to walk without aid or rest for 100m
6.0	Requires a walking aid – cane, crutch, etc. – to walk about 100m with or without resting

Score	Description
6.5	Requires two walking aids – pair of canes, crutches, etc. – to walk about 20m without resting
7.0	Unable to walk beyond approximately 5m even with aid. Essentially restricted to wheelchair; though wheels self in standard wheelchair and transfers alone. Up and about in wheelchair some 12 hours a day
7.5	Unable to take more than a few steps. Restricted to wheelchair and may need aid in transfering. Can wheel self but cannot carry on in standard wheelchair for a full day and may require a motorised wheelchair
8.0	Essentially restricted to bed or chair or pushed in wheelchair. May be out of bed itself much of the day. Retains many self-care functions. Generally has effective use of arms
8.5	Essentially restricted to bed much of day. Has some effective use of arms retains some self-care functions
9.0	Confined to bed. Can still communicate and eat
9.5	Confined to bed and totally dependent. Unable to communicate effectively or eat/swallow
10.0	Death due to MS

Rate of Perceived Exertion (RPE) and Borg Scale

BORG RPE	Modified RPE	BREATHING	% MAX HR
6	0	No exertion	50% - 60%
7		Very Light	
8	1		
9			
10	2	Notice breathing deeper, but still comfortable. Conversations possible.	60% - 70%
11			
12	3		
13		Aware of breathing harder; more difficult to hold a conversation	70% - 80%
14	4		
15	5	Starting to breathe hard and get uncomfortable	80% - 90%
16	6		
17	7	Deep and forceful breathing, uncomfortable, don't want to talk	90% - 100%
18	8		
19	9	Extremely hard	
20	10	Maximum exertion	

COLOR	BORG	Explanation/ Perceived Exertion
Green	6	No exertion at all
	7	Extremely light
	8	La, la, la :-)
Yellow	9	Very light - (easy walking slowly at a comfortable pace)
	10	This is the effort level where you can't hear your breathing,
	11	you're able to easily talk and you can run here for a very long time
	12	Light. Here you are building **aerobic endurance**.
Orange	13	Somewhat hard (It is quite an effort; you feel tired but can continue)
	14	You start to hear your breathing, not gasping for air.
	15	You can talk, but more challenging, use one- or two-word answers.
	16	Hard This is considered your **steady state**.
Red	17	Very hard (very strenuous, and you are very fatigued) **ANAEROBIC THRESHOLD**
	18	Breathing is vigorous. You can't talk, you're reaching for air.
	19	Extremely hard (You're counting the minutes until it ends)
	20	Maximal exertion

Six Minute Walk Test

The following elements should be present on the 6MWT worksheet and report:

Lap counter: _____ _____ _____

Patient name: _____ Patient ID# _____

Walk # _____ Tech ID: _____ Date: _____

Gender: M F Age: ____ Race: ____ Height: ___ft ____in, ____ meters

Weight: _____ lbs, _____kg Blood pressure: _____ / _____

Medications taken before the test (dose and time): _____

Supplemental oxygen during the test: No Yes, flow _____ L/min, type _____

	Baseline	End of Test
Time	___:___	___:___
Heart Rate	_____	_____
Dyspnea	____	____ (Borg scale)
Fatigue	____	____ (Borg scale)
SpO_2	____ %	____%

Stopped or paused before 6 minutes? No Yes, reason: _____

Other symptoms at end of exercise: angina dizziness hip, leg, or calf pain

Number of laps: ____ (×60 meters) + final partial lap: _____ meters =

Total distance walked in 6 minutes: _____ meters

Predicted distance: _____ meters Percent predicted: _____%

Tech comments:

Interpretation (including comparison with a preintervention 6MWD):

TINETTI BALANCE & GAIT ASSESSMENT

BODYWORKShfr.com

For both assessments, enter the date of each exam and circle your rating for each item. Indicate totals at the bottom of each section.

BALANCE ASSESSMENT

To perform this assessment, seat the patient in a hard, armless chair.

Evaluated Function	Description of Behavior	Date: ___	Date: ___
Sitting Balance	Leans or slides in chair	0	0
	Steady, safe	1	1
Rises From Chair	Unable to rise without help	0	0
	Able to rise using arms to help	1	1
	Able to rise without using arms to help	2	2
Attempts To Rise	Unable to rise without help	0	0
	Able to rise, requires more than one attempt	1	1
	Able to rise, requires one attempt	2	2
Standing Balance (1st 5 Seconds)	Unsteady (staggers, moves feet, trunk sways)	0	0
	Steady, but uses walker or other support	1	1
	Steady without walker or other support	2	2
Standing Balance	Unsteady	0	0
	Steady, but with wide stance and uses support	1	1
	Narrow stance without support	2	2
Nudged	Begins to fall	0	0
	Staggers, grabs, catches self	1	1
	Steady	2	2
Eyes Closed	Unsteady	0	0
	Steady	1	1
Turning 360 Degrees	Discontinuous steps	0	0
	Continuous steps	1	1
	Unsteady (grabs, staggers)	0	0
	Steady	1	1
Sitting Down (Getting Seated)	Unsafe (misjudged distance, falls into chair)	0	0
	Uses arms or not a smooth motion	1	1
	Safe, smooth motion	2	2
	Balance Score Potential Points: 16	___/16	___/16

GAIT ASSESSMENT

Stand with the patient. Walk across the room (+/- aids) at a usual pace, then rapidly

Evaluated Function	Description of Behavior	Date: ___	Date: ___
Indication of Gait	Any hesitancy or multiple attempts	0	0
	No hesitancy	1	1
Step Length & Height	Step to	0	0
	Step through right	1	1
	Step through left	1	1
Foot Clearance	Foot drop	0	0
	Left foot clears the floor	1	1
	Right foot clears the floor	1	1
Step Symmetry	Right and left step length are not equal	0	0
	Right and left step length appear equal	1	1
Step Continuity	Stopping of discontinuity between steps	0	0
	Steps appear continuous	1	1
Path	Marked deviation	0	0
	Mild/moderate deviation or uses a walking aid	1	1
	Straight without a walking aid	2	2
Trunk	Marked sway or uses a walking aid	0	0
	No sway, flexes knees/back/uses arms to balance	1	1
	No sway, no flexion of knees or back use of arms, or walking aid	2	2
Walking Time	Heels apart	0	0
	Heels almost touching while walking	1	1
	Gait Score Potential Points: 12	___/12	___/12

Combined Score Potential Points For Balance & Gait ___/28 ___/28

PT, Tinnetti Balance Assessment: 7/09

Risk of Falls: 18 Points or Less = High Risk, 19-23 Points = Moderate Risk, 24 or More Points = Low Risk

AFFIX STICKER

ELDERLY MOBILITY SCALE SCORE

Patient details……

TASK	Date			
Lying to Sitting	2 Independent 1 Needs help of 1 person 0 Needs help of 2+ people			
Sitting to Lying	2 Independent 1 Needs help of 1 person 0 Needs help of 2+ people			
Sitting to Standing	3 Independent in under 3 seconds 2 Independent in over 3 seconds 1 Needs help of 1 person 0 Needs help of 2+ people			
Standing	3 Stands without support and able to reach 2 Stands without support but needs support to reach 1 Stands but needs support 0 Stands only with physical support of another person			
Gait	3 Independent (+ / - stick) 2 Independent with frame 1 Mobile with walking aid but erratic / unsafe 0 Needs physical help to walk or constant supervision			
Timed Walk (6 metres)	3 Under 15 seconds 2 16 – 30 seconds 1 Over 30 seconds 0 Unable to cover 6 metres			
	Recorded time in seconds.			
Functional Reach	4 Over 20 cm. 2 10 - 20 cm. 0 Under 10 cm.			
	Actual reach			
	SCORES	**/ 20**	**/ 20**	**/ 20**
	Staff Initials			

Scores under 10 – generally these patients are **dependent** in mobility manoeuvres; require help with basic ADL, such as transfers, toileting and dressing.

Scores between 10 – 13 – generally these patients are **borderline** in terms of safe mobility and independence in ADL i.e. they require some help with some mobility manoeuvres.

Scores over 14 – Generally these patients are able to perform mobility manoeuvres alone and safely and are **independent** in basic ADL.

Johns Hopkins

Fall Risk Assessment Tool

If patient has any of the following conditions, check the box and apply Fall Risk interventions as indicated.

High Fall Risk - Implement High Fall Risk interventions per protocol

- ☐ History of more than one fall within 6 months before admission
- ☐ Patient has experienced a fall during this hospitalization
- ☐ Patient is deemed high fall-risk per protocol (e.g., seizure precautions)

Low Fall Risk - Implement Low Fall Risk interventions per protocol

- ☐ Complete paralysis or completely immobilized

Do not continue with Fall Risk Score Calculation if any of the above conditions are checked.

FALL RISK SCORE CALCULATION – Select the appropriate option in each category. Add all points to calculate Fall Risk Score. (If no option is selected, score for category is 0)	**Points**
Age *(single-select)* ☐ 60 - 69 years (1 point) ☐ 70 -79 years (2 points) ☐ greater than or equal to 80 years (3 points)	
Fall History *(single-select)* ☐ One fall within 6 months before admission (5 points)	
Elimination, Bowel and Urine *(single-select)* ☐ Incontinence (2 points) ☐ Urgency or frequency (2 points) ☐ Urgency/frequency and incontinence (4 points)	
Medications: Includes PCA/opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, sedatives, and psychotropics *(single-select)* ☐ On 1 high fall risk drug (3 points) ☐ On 2 or more high fall risk drugs (5 points) ☐ Sedated procedure within past 24 hours (7 points)	
Patient Care Equipment: Any equipment that tethers patient (e.g., IV infusion, chest tube, indwelling catheter, SCDs, etc.) *(single-select)* ☐ One present (1 point) ☐ Two present (2 points) ☐ 3 or more present (3 points)	
Mobility *(multi-select; choose all that apply and add points together)* ☐ Requires assistance or supervision for mobility, transfer, or ambulation (2 points) ☐ Unsteady gait (2 points) ☐ Visual or auditory impairment affecting mobility (2 points)	
Cognition *(multi-select; choose all that apply and add points together)* ☐ Altered awareness of immediate physical environment (1 point) ☐ Impulsive (2 points) ☐ Lack of understanding of one's physical and cognitive limitations (4 points)	
Total Fall Risk Score (Sum of all points per category)	
SCORING: 6-13 Total Points = Moderate Fall Risk, >13 Total Points = High Fall Risk	

Fall Risk – Hendrich II Scale

Risk Factor	Risk Points	
Confusion/Disorientation	4	
Depression	2	
Altered Elimination	1	
Dizziness/Vertigo	1	
Gender (Male)	1	
Any prescribed antiepileptic (anticonvulsants): *(carbamazepine, divalproex, sodium, ethotoin, felbamate, fosphenytoin, gabapentin, lamotrigine, mephenytoin, methsuximide, phenobarbitol, phenytoin, primidone, topiramate, trimethadione, valproic acid).*	2	
Any prescribed benzodiazepines: *(alprazolam, buspirone, chlordiazepoxide, clonazepam, clorazepate dipotassium, diazepam, flurazepam, halazepam, lorazepam, midazolam, oxazepam, temazepam, triazolam)*	1	
Get-up-and-go* Test: "Rising from Chair" ** If unable to asses (unconscious, drug-induced coma, traction, extreme debilitation/atrophy), monitor for change in activity level and use all other risk factor scores.*		
Please choose only one score		
Able to rise in single movement	0	
Pushes up, Successful in one attempt	1	
Multiple attempts but successful	3	
Unable to rise without assistance	4	
Total *(A score of five or greater equals High Risk)*		

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name _____ Evaluator's Name_____ Date of Assessment

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 2 of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort..				
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours				
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.				
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
					Total Score			

Global Assessment of Functioning (GAF) Scale

AMA Guides, 6th Edition

Global Assessment of Functioning (GAF) Impairment Score

GAF	Description	GAF Impairment Score
91–100	Superior functioning in a wide range of activities; life's problems never seem to get out of hand; is sought out by others because of his or her many positive qualities. No symptoms.	0%
81–90	Absent or minimal symptoms (eg, mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (eg, an occasional argument with family members)	0%
71–80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (eg, difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (eg, temporarily falling behind in school work)	0%
61–70	Some mild symptoms (eg, depressed mood and mild insomnia) *or* some difficulty in social, occupational, or school functioning (eg, occasional truancy, or theft within the household) but generally functioning pretty well, has some meaningful interpersonal relationships	5%
51–60	Moderate symptoms (eg, flat affect and circumstantial speech, occasional panic attacks) *or* moderate difficulty in social, occupational, or school functioning (eg, few friends, conflicts with coworkers)	10%
41–50	Serious symptoms (eg, suicidal ideation, severe obsessional rituals, frequent shoplifting) *or* any serious impairment in social, occupational, or school functioning (eg, no friends, unable to keep a job)	15%
31–40	Some impairment in reality testing or communication (eg, speech is at times illogical, obscure, or irrelevant) *or* major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (eg, depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school)	20%
21–30	Behavior is considerably influenced by delusions or hallucinations *or* serious impairment in communication or judgment (eg, sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) *or* inability to function in almost all areas (eg, stays in bed all day; no job, home, or friends)	30%
11–20	Some danger of hurting self or others (eg, suicide attempts without clear expectation of death, frequently violent, manic excitement) *or* occasionally fails to maintain minimal personal hygiene (eg, smears feces) *or* gross impairment in communication (eg, largely incoherent or mute)	40%
1–10	Persistent danger of severely hurting self or others (eg, recurrent violence) *or* persistent inability to maintain minimal personal hygiene *or* serious suicidal act with clear expectation of death	50%

The Karnofsky Performance Scale Index allows patients to be classified as to their functional impairment. This can be used to compare effectiveness of different therapies and to assess the prognosis in individual patients. The lower the Karnofsky score, the worse the survival for most serious illnesses.

KARNOFSKY PERFORMANCE STATUS SCALE DEFINITIONS RATING (%) CRITERIA

Able to carry on normal activity and to work; no special care needed.	100	Normal no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal activity with effort; some signs or symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of his personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	40	Disabled; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death not imminent.
	20	Very sick; hospital admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.
	0	Dead

References:

Crooks, V, Waller S, et al. The use of the Karnofsky Performance Scale in determining outcomes and risk in geriatric outpatients. J Gerontol. 1991; 46: M139-M144.

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Hollen PJ, Gralla RJ, et al. Measurement of quality of life in patients with lung cancer in multicenter trials of new therapies. Cancer. 1994; 73: 2087-2098.

O'Toole DM, Golden AM. Evaluating cancer patients for rehabilitation potential. West J Med. 1991; 155:384-387.

Oxford Textbook of Palliative Medicine, Oxford University Press. 1993;109.

Schag CC, Heinrich RL, Ganz PA. Karnofsky performance status revisited: Reliability, validity, and guidelines. J Clin Oncology. 1984; 2:187-193.

Sequential Organ Failure Assessment (SOFA) Score Scale

Variable	0	1	2	3	4	Score (04)
Pa02/Fi02 mmHg	> 400	< 400	< 300	< 200	< 100	
Platelets, x 10^3/µL (x 10^6/L)	> 150 (> 150)	< 150 (< 150)	< 100 (< 100)	< 50 (< 50)	< 20 (< 20)	
Bilirubin, mg/dL (µmol/L)	< 1.2 (< 20)	1.2 - 1.9 (20 - 32)	2.0 - 5.9 (33 - 100)	6.0 - 11.9 (101 - 203)	> 12 (> 203)	
Hypotension	None	MABP < 70 mmHg	Dop < 5	Dop 6 - 15 or Epi < 0.1 or Norepi < 0.1	Dop > 15 or Epi > 0.1 or Norepi > 0.1	
Glasgow Coma Scale Score (see next page to calculate)	15	13 - 14	10 - 12	6 - 9	< 6	
Creatinine, mg/dL (µmol/L)	< 1.2 (< 106)	1.2 .1.9 (106 - 168)	2.0 - 3.4 (169 - 300)	3.5 - 4.9 (301 - 433)	> 5 (> 434)	
				TOTAL (0 - 24):		

Dopamine [Dop], epinephrine [Epi], and norepinephrine [Norepi] doses in µg/kg/min (administered for at least one hour). SI units in parentheses ( )

Explanation of variables:

- Pa02/Fi02 indicates the level of oxygen in a patient's blood.
- Platelets are a critical component of blood clotting.
- Bilirubin is measured by a blood test and indicates liver function.
- Hypotension indicates low blood pressure; scores of 2, 3, and 4 indicate that blood pressure must be maintained by the use of powerful medications that require ICU monitoring (including dopamine, epinephrine, and norepinephrine).
- The Glasgow Coma Scale Score is a standardized measure that indicates neurologic function; low score indicates poorer function. See the worksheet on next page to calculate the score.
- Creatinine is measured by a blood test and indicates kidney function.

SUPERVISORY CHECKLIST
POTENTIAL SYMPTOMS OF ACUTE IMPAIRMENT

The following is a checklist to help identify whether an employee may be acutely impaired. Potential causes of impairment may include substance abuse, mental illness, personal stress, etc. The checklist is a tool to aid supervisors in determining whether it is appropriate to refer the employee to the Employee Assistance Program (EAP) or Occupational Health for further evaluation, or to justify a request for drug testing under the Reasonable Suspicion component of the Federal Drug-Free Workplace Program.

Employee: _____ Date: _____

Department: _____ Time: _____

Observed Behaviors (TODAY)

Alertness, Appearance, Demeanor:

___ Teary
___ Drowsy
___ Agitated
___ Confused
___ Uncooperative
___ Difficulty concentrating
___ Wide swings in emotions
___ Combative without provocation
___ Inappropriate euphoria (too happy)
___ Improbable excuses for behavior
___ Unusual flare-up or outbreak of anger
___ Over-reaction to real or imagined criticism
___ Seems unable to respond rationally to simple questions

Speech Pattern:

___ Slurring
___ Incoherent speech
___ Other (Describe below)
___ Inability to form words
___ Repeating nonsense words/phrases

Breath:

___ Garlicky
___ Alcohol like
___ Sweet

Eyes, Expression:

___ "Blood shot"
___ Glazed over, "Glassy eyed"
___ Very large pupils
___ Very small pupils

Narrative detail associated with above observations:

_____

_____

_____

_____

_____

_____

Walking, Standing, Movement

___ Holding onto objects for support
___ Inability to walk normally
___ Safety violation, accident
___ Careless operation of equipment

General Observations

___ Not in duty area
___ Physical illness at work (detail below)
___ Tardy; late return from lunch or breaks
___ Sudden change in quality or output of work
___ Clothing inappropriate for weather or surroundings

Narrative detail of (today's) incident prompting the above observations, or with action taken as described below: (have confirmed if possible)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Actions Taken/Disposition:

Employee escorted for evaluation/referral:

_____ ER/Occupational Health Escorted by: _____

_____ EAP Date/time: _____

Yes No Was Employee evaluated in ER or Occupational Health?

Yes No Was Employee referred to EAP?

Yes No Did employee leave the hospital?

Yes No Was transportation arranged? _____

(Circle One)

Supervisor Signature: _____ **Date:** _____

Confirmation: _____ **Date:** _____

(if appropriate -- Can be another management official, or a medical professional if employee was referred.)

SUPERVISORY CHECKLIST
POTENTIAL SYMPTOMS OF CHRONIC IMPAIRMENT

The following is a checklist to help identify whether an employee may be chronically impaired. Potential causes of impairment may include substance abuse, mental illness, personal stress, etc. The checklist is a tool to aid supervisors in determining whether it is appropriate to refer the employee to the Employee Assistance Program (EAP) or Occupational Health for further evaluation, or to justify a request for drug testing under the Reasonable Suspicion component of the Federal Drug-Free Workplace Program.

Employee: _____ Date: _____

Department: _____ Time: _____

Pattern of Observed Changes in:

Attendance / Illness:

___ Pattern of returning late from lunch or breaks, etc.

___ Absent from duty area more frequently than is required by the job; for example, too-frequent trips to rest room, water fountain, etc. (Explain below)

___ Higher absenteeism than average employee for colds, flu, other malaise.

___ Tardiness / leaving early

___ Prolonged, unpredicted absences

___ Takes mysterious medications

___ Improbable excuses for absences

___ Physical illness at work

___ Has attempted to hide drinking

Relationships / Attitude:

___ Lies; makes excuses

___ Borrows money from others

___ Increasingly cynical or hostile

___ Refuses to discuss problems

___ Record of money or legal problems

___ Episodes of lost temper

___ Unreasonable resentment; irritability

___ Avoids supervisor or co-workers

___ Wide swings in mood or morale

___ Overreacts to real or imagined criticism

___ Domestic problems interfere with work

___ Has expressed cold, callous, or aggressive feelings or opinions about others

Narrative detail associated with above observations _____

_____

_____

_____

_____

_____

_____

Accident Rate / OWCP:

___ Accidents at work
___ Accidents off the job
___ Frequent referrals to Employee Health

Job Performance:

___ Assignments take longer
___ Increasing mistakes
___ Exaggerates accomplishments
___ Confused; Doesn't pay attention
___ Sporadic (high and low) productivity
___ Resistant to instructions
___ Misses deadlines
___ Wastes materials
___ Difficulty recalling instructions, details, etc.
___ Difficulty recalling own mistakes
___ Improbable excuses for poor performance
___ Hand tremor when concentrating
___ Performance is far below acceptable level (Explain below)
___ Frequently reports/returns to duty in an obviously abnormal condition
___ Complaints from co-workers or others (Explain below)

Narrative detail associated with above observations, or with action described below:

_____

_____

_____

_____

_____

_____

Actions Taken/Disposition:

Employee escorted for evaluation/referral:

_____ ER/Occupational Health
_____ EAP
Escorted by: _____
Date/time: _____

Yes No Was Employee evaluated in ER or Occupational Health?
Yes No Was Employee referred to EAP?
Yes No Did employee leave the hospital?
Yes No Was transportation arranged? _____
(Circle One)

Supervisor Signature: _____ **Date:** _____

Confirmation: _____ **Date:** _____
(if appropriate -- Can be another management official, or a medical professional if employee was referred.)