DATE: ENCOUNTER

Please select the ONE best answer for your abilities at this time: NAME_____

OVER THE LAST WEEK, were you able to:	Without any Difficulty	With Some Difficulty	With much Difficulty	Unable Difficulty
Dress yourself including tying shoelaces and doing buttons?	❍	❍	❍	❍
Get in and out of bed:	❍	❍	❍	❍
Lift a full cup or glass to your mouth?	❍	❍	❍	❍
Walk outdoors on flat ground?	❍	❍	❍	❍
Wash and dry your entire body?	❍	❍	❍	❍
Bend down to pick up clothing from the floor?	❍	❍	❍	❍
Turn faucets on and off?	❍	❍	❍	❍
Get in and out of a car, bus, or airplane?	❍	❍	❍	❍
Walk two miles if you wish?	❍	❍	❍	❍
Participate in recreational activities and sports, if you wish?	❍	❍	❍	❍
Get a good night's sleep?	❍	❍	❍	❍
Deal with feelings of anxiety or being nervous?	❍	❍	❍	❍
Deal with feelings of depression or feeling blue?	❍	❍	❍	❍

HOW MUCH PAIN HAVE YOU HAD BECAUSE OF YOUR CONDITION OVER THE PAST WEEK?

Please indicate how severe your pain has been:

NO	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	**Severe**
Pain	**0**	**0.5**	**1**	**1.5**	**2**	**2.5**	**3**	**3.5**	**4**	**4.5**	**5**	**5.5**	**6**	**6.5**	**7**	**7.5**	**8**	**8.5**	**9**	**9.5**	**10**	**Pain**

Please check in the appropriate spot to indicate the amount of pain you are having TODAY in each of the joint areas listed below:

	NONE	MILD	MODERATE	SEVERE		NONE	MILD	MODERATE	SEVERE
LEFT FINGERS	❍	❍	❍	❍	**RIGHT FINGERS**	❍	❍	❍	❍
LEFT WRIST	❍	❍	❍	❍	**RIGHT WRIST**	❍	❍	❍	❍
LEFT ELBOW	❍	❍	❍	❍	**RIGHT ELBOW**	❍	❍	❍	❍
LEFT SHOULDER	❍	❍	❍	❍	**RIGHT SHOULDER**	❍	❍	❍	❍
LEFT HIP	❍	❍	❍	❍	**RIGHT HIP**	❍	❍	❍	❍
LEFT KNEE	❍	❍	❍	❍	**RIGHT KNEE**	❍	❍	❍	❍
LEFT ANKLE	❍	❍	❍	❍	**RIGHT ANKLE**	❍	❍	❍	❍
LEFT TOES	❍	❍	❍	❍	**RIGHT TOES**	❍	❍	❍	❍
NECK	❍	❍	❍	❍	**Back**	❍	❍	❍	❍

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

VERY	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	**VERY**
WELL	**0**	**0.5**	**1**	**1.5**	**2**	**2.5**	**3**	**3.5**	**4**	**4.5**	**5**	**5.5**	**6**	**6.5**	**7**	**7.5**	**8**	**8.5**	**9**	**9.5**	**10**	**POOR**

Please check below if you have experienced any of the following in the last months: ❍ **NONE**

❍ Fever	❍ Problem with Hearing	❍ Vomiting	❍ Joint Pain
❍ Weight Gain	❍ Ringing in the Ears	❍ Constipation	❍ Back Pain
❍ Weight Loss	❍ Stuffy Nose	❍ Diarrhea	❍ Neck Pain
❍ Feeling Sickly	❍ Sores in Mouth	❍ Dark or Bloody Stools	❍ Use of drugs not sold in stores
❍ Headaches	❍ Dry Mouth	❍ Problems with Urination	❍ Smoking Cigarettes
❍ Unusual Fatigue	❍ Problems with smell or taste	❍ Gynecologic Problems	❍ More than 2 Alcoholic drinks/day
❍ Swollen Glands	❍ Lump in Throat	❍ Dizziness	❍ Depression
❍ Loss of Appetite	❍ Cough	❍ Losing your Balance	❍ Anxiety
❍ Skin Rash	❍ Shortness of Breath	❍ Muscle Pain, Aches, or Cramps	❍ Problems with Thinking
❍ Hives	❍ Wheezing	❍ Muscle Weakness	❍ Problems with Memory
❍ Easy Bleeding	❍ Pain in Chest	❍ Paralysis of Arms or Legs	❍ Problems with Sleeping
❍ Easy Bruising	❍ Heart Pounding (palpitations)	❍ Numbness/Tingling of Arms or Legs	❍ Sexual Problems
❍ Other Skin Problems	❍ Trouble Swallowing (dysphagia)	❍ Fainting Spells (syncope)	❍ Burning in Sex Organs
❍ Loss of Hair	❍ Heartburn	❍ Swelling of Hands	❍ Problems with Social Activities
❍ Dry Eyes	❍ Stomach Pain or Cramps	❍ Swelling of Ankles	
❍ Other Eye Problems	❍ Nausea	❍ Swelling in Other Joints	