Valerius Medical Group
Advanced, patient-focused care for inflammatory & autoimmune disorders

Name: _____ **Date:** _____

Med Record No:_____

Patient Health Measures

We are interested in learning how your illness affects your ability to function in daily life. Place an "X" in the box which best describes your usual abilities *OVER THE PAST WEEK*:

Are you able to:	Without Any Difficulty (0)	With Some Difficulty (1)	With Much Difficulty (2)	Unable to Do (3)
Dress yourself, including shoelaces and buttons?	☐	☐	☐	☐
Shampoo your hair?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
Stand up from a straight chair?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Cut your meat?	☐	☐	☐	☐
Open a new milk carton?	☐	☐	☐	☐
Walk out doors on flat ground?	☐	☐	☐	☐
Climb up five steps?	☐	☐	☐	☐

	Without Any Difficulty (0)	With Some Difficulty (1)	With Much Difficulty (2)	Unable to Do (3)
Wash and dry your body?	☐	☐	☐	☐
Get on and off the toilet	☐	☐	☐	☐
Take a tub bath?	☐	☐	☐	☐
Bend down to pick up clothing from the floor?	☐	☐	☐	☐
Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
Turn faucets on and off?	☐	☐	☐	☐
Open jars that have been previously opened?	☐	☐	☐	☐
Open car doors?	☐	☐	☐	☐
Get in and out of a car?	☐	☐	☐	☐
Run errands and shop?	☐	☐	☐	☐
Do chores such as vacuuming or yard work?	☐	☐	☐	☐

PLEASE CONTINUE TO THE NEXT PAGE

Patient Name:_____ Date:_____

Below is a list of statements that other people with your illness have said are important. **By circling one (1) number per line, please indicated how true each statement has been for you during the past 7 days.**

	Not at all	A little bit	Some-what	Quite a bit	Very much
I feel fatigued	0	1	2	3	4
I feel weak all over	0	1	2	3	4
I feel listless ("washed out")	0	1	2	3	4
I feel tired	0	1	2	3	4
I have trouble starting things because I am tired	0	1	2	3	4
I have trouble finishing things because I am tired	0	1	2	3	4
I have no energy	0	1	2	3	4
I am unable to do my usual activities	0	1	2	3	4
I need to sleep during the day	0	1	2	3	4
I am too tired to eat	0	1	2	3	4
I need help doing my usual activities	0	1	2	3	4
I am frustrated by being too tired to do the things I want to do	0	1	2	3	4
I have to limit my social activity because I am tired	0	1	2	3	4

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and check (√) your response in the appropriate box.	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling asleep, staying asleep, or sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				
6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down.				
7. Trouble concentrating on things such as reading the newspaper or watching television.				
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.				
9. Thinking that you would be better off dead or that you want to hurt yourself in some way				

PLEASE CONTINUE TO THE NEXT PAGE

Patient Name:_____ Date:_____

CONSIDERING ALL THE WAYS THAT YOUR ILLNESS AFFECTS YOU, rate how you are doing on the following scale. Place an "X" in the box below that best describes how you are doing on a scale of 0-10.

◊ ◊

VERY WELL 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0 **VERY POORLY**

HOW MUCH PAIN HAVE YOU HAD BECAUSE OF YOUR ILLNESS IN THE PAST WEEK? Place an "X" in the box below that best describes your pain on a scale of 0-10.

◊ ◊

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0

NO PAIN **SEVERE PAIN**

STOP – FOR OFFICE USE ONLY – NO MARKS BELOW THIS POINT

Health Assessment Questionnaire Scale:

	1	0.125		5	0.625		9	1.125		13	1.625		17	2.125		21	2.625						
	2	0.250		6	0.750		10	1.250		14	1.750		18	2.250		22	2.750						
	3	0.375		7	0.875		11	1.375		15	1.875		19	2.375		23	2.875						
	4	0500		8	1.000		12	1.500		16	2.000		20	2.500		24	3.000						

FACIT – Fatigue Scale:

	1	**0.077**		**10**	**0.769**		**19**	**1.462**		**28**	**2.154**		**37**	**2.846**		**46**	**3.538**						
	2	**0.154**		**11**	**0.846**		**20**	**1.538**		**29**	**2.231**		**38**	**2.923**		**47**	**3.615**						
	3	**0.231**		**12**	**0.923**		**21**	**1.615**		**30**	**2.308**		**39**	**3.000**		**48**	**3.692**						
	4	**0.308**		**13**	**1.000**		**22**	**1.692**		**31**	**2.385**		**40**	**3.077**		**49**	**3.769**						
	5	**0.385**		**14**	**1.077**		**23**	**1.769**		**32**	**2.462**		**41**	**3.154**		**50**	**3.846**						
	6	**0.462**		**15**	**1.154**		**24**	**1.846**		**33**	**2.538**		**42**	**3.231**		**51**	**3.923**						
	7	**0.538**		**16**	**1.231**		**25**	**1.923**		**34**	**2.615**		**43**	**3.308**		**52**	**4.000**						
	8	**0.615**		**17**	**1.308**		**26**	**2.000**		**35**	**2.692**		**44**	**3.385**										
	9	**0.692**		**18**	**1.385**		**27**	**2.077**		**36**	**2.769**		**45**	**3.462**										

Current **Prior: _____**

HAQ = _____ _____

FACIT = _____ _____

PHQ-9 =: _____ _____

Patient Global: _____ _____

Pain Score = _____ _____