### KAPS Minimal Data Collection

 

Short Questionnaire

The following questions are about the aches, pain or stiffness you visited your doctor or nurse with approximately **7 months ago** (we will refer to this as your **“pain condition”**). According to our records, from your response to the first questionnaire, **your pain condition was in**…

|  |  |  |
| --- | --- | --- |
|  | Affix sticker here |  |
|  |  |
|  |  |
|  |  |

For each of the following questions, please cross one box.

|  |
| --- |
| 1) Compared with when you saw your doctor or nurse with this pain condition approximately 7 months ago, how do you feel your **pain** is **now**? |
| Completely recovered | Much better | Better | No change | Worse | Much worse |
|  |  |  |  |  |  |

2) In the **last 2 weeks**, on **average**, how intense was your **usual** pain rated on a 0-10 scale, where 0 is ‘no pain’ and 10 is ‘pain as bad as could be’?

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | No pain |  |  |  |  |  |  |  |  |  | Pain as bad as could be |
|  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|  |  |  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| 3) In general, would you say your health is:  |
| Excellent | Very Good | Good | Fair | Poor |
|  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 4) Thinking now about your **pain condition**, please cross one box for each of these questions. In the past 7 days…

|  |
| --- |
| a) How much did this pain interfere with your enjoyment of life? |
| Not at all | A little bit | Somewhat | Quite a bit | Very much |
|  |  |  |  |  |

|  |
| --- |
| b) How much did this pain interfere with your ability to concentrate? |
| Not at all | A little bit | Somewhat | Quite a bit | Very much |
|  |  |  |  |  |

|  |
| --- |
| c) How much did this pain interfere with your day to day activities? |
| Not at all | A little bit | Somewhat | Quite a bit | Very much |
|  |  |  |  |  |

|  |
| --- |
| d) How much did this pain interfere with doing tasks away from home (e.g. getting groceries, running errands)? |
| Not at all | A little bit | Somewhat | Quite a bit | Very much |
|  |  |  |  |  |

|  |
| --- |
| e) How much did this pain interfere with your enjoyment of recreational activities? |
| Not at all | A little bit | Somewhat | Quite a bit | Very much |
|  |  |  |  |  |

|  |
| --- |
| f) How often did this pain keep you from socialising with others? |
| Never | Rarely | Sometimes | Often | Always |
|  |  |  |  |  |

5) Compared to one year ago, how would you rate your **health in general** now? |
| Much better now than one year ago | Somewhat better now than one year ago | About the same as one year ago | Somewhat worse now than one year ago | Much worse now than one year ago |
|  |  |  |  |  |

6) The following questions are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes, limited a lot | Yes, limited a little | No, not limited at all |
| a) **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, playing golf. |  |  |  |
| b) Climbing **several** flights of stairs. |  |  |  |

7) During the **past four weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| a) **Accomplished less** than you would like |  |  |  |  |  |
| b) Were limited in the **kind** or work or other activities |  |  |  |  |  |

8) During the **past four weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| a) **Accomplished less** than you would like |  |  |  |  |  |
| b) Did work or other activities **less carefully than usual** |  |  |  |  |  |

9) During the past **four weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not at all | A little bit | Moderately | Quite a bit | Extremely |
|  |  |  |  |  |

10) These questions are about how you feel and how things have been with you **during the past four weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How much time **during the past four weeks**… | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| a) Have you felt calm and peaceful? |  |  |  |  |  |
| b) Did you have a lot of energy? |  |  |  |  |  |
| c) Have you felt downhearted and depressed? |  |  |  |  |  |

11) During the **past four weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|  |  |  |  |  |

Now please fill in the date **you completed this questionnaire:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Day |  | Month |  | Year |
|  |  |  |  |  |  |
|  |  |  |  |  |  | 2 | 0 |  |  |

**Thank you very much for filling in this short questionnaire.**

*Please place the questionnaire in the envelope provided and post back to us (no stamp is needed).*

Study ID number



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