FOCUS Health Assessment Questionnaire

Name _____ Date _____

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)
Stand up from a straight chair?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Get on and off the toilet?	☐	☐	☐	☐
Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
Open car doors?	☐	☐	☐	☐
Do yard work (outside work or activities)?	☐	☐	☐	☐
Wait in a line for 15 minutes?	☐	☐	☐	☐
Lift heavy objects?	☐	☐	☐	☐
Move heavy objects?	☐	☐	☐	☐
Go up two or more flights of stairs?	☐	☐	☐	☐

We are also interested in knowing about any problems that you may have been having with fatigue. How much of a problem has fatigue or tiredness been for you IN THE PAST WEEK? Place an X in the box below that best describes the severity of your fatigue on a scale of 0 – 10.

FATIGUE IS NO PROBLEM 0 ☐ 5 ☐ ☐ ☐ ☐ 10 FATIGUE IS A MAJOR PROBLEM

We are also interested in learning whether or not you are affected by pain because of your illness. How much pain have you had because of your illness in the past week? Place an X in the box that best describes the severity of your pain on a scale of 0 – 10.

NO PAIN 0 ☐ 5 ☐ ☐ ☐ ☐ 10 SEVERE PAIN

How satisfied are you with your HEALTH NOW?

☐ Very Satisfied ☐ Somewhat Satisfied ☐ Neither Satisified nor Dissatisfied ☐ Somewhat Dissatisfied ☐ Very Dissatisfied