

# **IMACS FORM 05a: HEALTH ASSESSMENT QUESTIONNAIRE**

Subject's IMACS number \_\_\_\_\_  
Person Completing: \_\_\_ Patient \_\_\_ Other: Relationship \_\_\_\_\_  
Date of assessment (mm/dd/yy) \_\_\_\_\_ Assessment number \_\_\_\_\_

In this section we are interested in learning how your illness affects your ability to function in daily life. Please feel free to add any comments on the back of this page.

**Please check the response which best describes your usual abilities OVER THE PAST WEEK:**

	Without ANY difficulty <sup>0</sup>	With SOME difficulty <sup>1</sup>	With MUCH difficulty <sup>2</sup>	UNABLE to do <sup>3</sup>
<b>DRESSING &amp; GROOMING</b>				
Are you able to:				
-Dress yourself, including tying shoelaces, and doing buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ARISING</b>				
Are you able to:				
-Stand up from a straight chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Get in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EATING</b>				
Are you able to:				
-Cut your meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Lift a full cup or glass to your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Open a milk carton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>WALKING</b>				
Are you able to:				
-Walk outdoors on flat ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Climb up five steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please check any AIDS OR DEVICES that you usually use for any if these activities:**

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Cane       | <input type="checkbox"/> Devices used for dressing (button hook, zipper pull, shoe horn, etc.) |
| <input type="checkbox"/> Walker     | <input type="checkbox"/> Special or built up utensils  |
| <input type="checkbox"/> Crutches   | <input type="checkbox"/> Special or built up chair   |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Other (specify: _____)  |

**Please check any categories for which you usually need HELP FROM ANOTHER PERSON:**

- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> Dressing and Grooming | <input type="checkbox"/> Eating  |
| <input type="checkbox"/> Arising               | <input type="checkbox"/> Walking |

Subject's IMACS number \_\_\_\_\_ Person Completing: \_\_\_Patient \_\_\_Other  
 Date of assessment (mm/dd/yy) \_\_\_\_\_ Assessment number \_\_\_\_\_

**Please check the response which best describes your usual abilities OVER THE PAST WEEK:**

	<u>Without ANY</u> <u>difficulty</u> <sup>0</sup>	<u>With SOME</u> <u>difficulty</u> <sup>1</sup>	<u>With MUCH</u> <u>difficulty</u> <sup>2</sup>	<u>UNABLE</u> <u>to do</u> <sup>3</sup>
--	--	--	--	--

**HYGENE**

Are you able to:

- |                            |                          |                          |                          |                          |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| -Wash and dry your body?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| -Take a tub bath           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| -Get on and off the toilet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**REACH**

Are you able to:

- |  |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| -Reach and get down a 5-pound object (such as a bag of sugar) from just above your head? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| -Bend down to pick up clothing from floor?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**GRIP**

Are you able to:

- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| -Open car doors?                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| -Open jars which have been previously opened? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| -Turn faucets on and off?                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**ACTIVITIES**

Are you able to:

- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| -Run errands and shop?                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| -Get in and out of a car?                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| -Do chores such as vacuuming or yardwork? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Please check any AIDS or DEVICES that you usually use for any activities:**

- |  |  |
|--|--|
| <input type="checkbox"/> Raised toilet seat                      | <input type="checkbox"/> Bathtub bar                         |
| <input type="checkbox"/> Bathtub seat                            | <input type="checkbox"/> Long-handled appliances for reach   |
| <input type="checkbox"/> Jar opener (for jars previously opened) | <input type="checkbox"/> Long-handled appliances in bathroom |
|  | <input type="checkbox"/> Other (specify _____)               |

**Please check any categories for which you usually need HELP FROM ANOTHER PERSON:**

- |                                  |  |
|----------------------------------|--|
| <input type="checkbox"/> Hygiene | <input type="checkbox"/> Gripping and opening things |
| <input type="checkbox"/> Reach   | <input type="checkbox"/> Errands and chores          |

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 A VERTICAL ( | ) MARK ON THE LINE TO INDICATE THE SEVERITY OF PAIN**

**NO  
PAIN**

**SEVERE  
PAIN**

**0**

**100**