ID No

C5. HEALTH AND WELLBEING: GENERAL HEALTH

We would like to know how you have been feeling over the past few weeks.

Please colour in the circle that most closely describes your experience in each question.

Have you recently?

	Better than usual	Same as usual	Less than usual	Much less than usual
1. Been able to concentrate on what you're doing?	○	○	○	○

	Not at all	No more than usual	Rather more than usual	Much more than usual
2. Lost much sleep over worry?	○	○	○	○

	More so than usual	Same as usual	Less useful than usual	Much less useful
3. Felt you were playing a useful part in things?	○	○	○	○

	More so than usual	Same as usual	Less so than usual	Much less capable
4. Felt capable of making decisions about things?	○	○	○	○

	Not at all	No more than usual	Rather more than usual	Much more than usual
5. Felt constantly under strain?	○	○	○	○

	Not at all	No more than usual	Rather more than usual	Much more than usual
6. Felt you couldn't overcome your difficulties?	○	○	○	○

	More so than usual	Same as usual	Less so than usual	Much less than usual
7. Been able to enjoy your normal day-to-day activities?	○	○	○	○

	More so than usual	Same as usual	Less so than usual	Much less able
8. Been able to face up to your problems?	○	○	○	○

	Not at all	No more than usual	Rather more than usual	Much more than usual
9. Been feeling unhappy and depressed?	○	○	○	○

	Not at all	No more than usual	Rather more than usual	Much more than usual
10. Been losing confidence in yourself?	○	○	○	○

	Not at all	No more than usual	Rather more than usual	Much more than usual
11. Been thinking of yourself as a worthless person?	○	○	○	○

	More so than usual	About same as usual	Less so than usual	Much less than usual
12. Been feeling reasonably happy, all things considered?	○	○	○	○

C6. HEALTH AND WELLBEING: GENERAL HEALTH

Under each heading, please colour in the **ONE** circle that best describes your health **TODAY.**

INTELLECTUAL ACTIVITIES

- ○ I have no problems with intellectual activities
- ○ I have slight problems with intellectual activities
- ○ I have moderate problems with intellectual activities
- ○ I have severe problems with intellectual activities
- ○ I am unable to perform intellectual activities

SHEEHAN DISABILITY SCALE

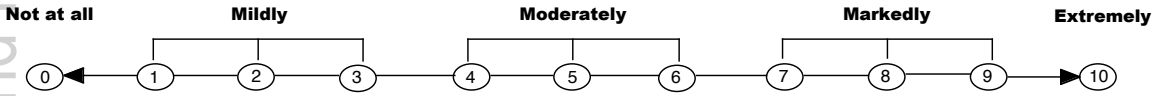
A BRIEF, PATIENT RATED, MEASURE OF DISABILITY AND IMPAIRMENT

Please mark ONE circle for each scale.

In the past (timeframe):

WORK* / SCHOOL

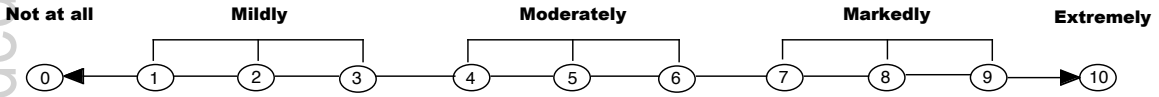
The symptoms have disrupted your work / school work:



☐ I have not worked /studied at all during the past week **for reasons unrelated to the disorder**.
* Work includes paid, unpaid volunteer work or training. If your symptoms interfered with your ability to find or hold a job or contributed in any way to your currently not working, you must give a score on this scale.

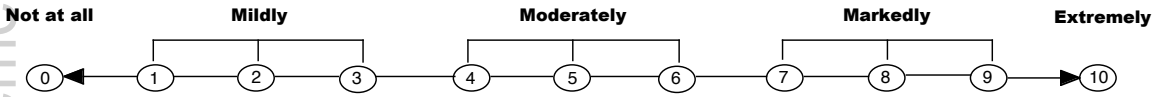
SOCIAL LIFE

The symptoms have disrupted your social life / leisure activities:



FAMILY LIFE / HOME RESPONSIBILITIES

The symptoms have disrupted your family life / home responsibilities:



DAYS LOST

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? _____

DAYS UNDERPRODUCTIVE

On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work or had other daily responsibilities, your productivity was reduced? ____

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C2. HEALTH AND WELLBEING: POST-TRAUMATIC STRESS

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then colour in the circle that indicates how much you have been bothered by that problem in the past month.

	Not at all	A litle bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing memories, thoughts, or images of a stressful military experience?	○	○	○	○	○
2. Repeated, disturbing dreams of a stressful military experience?	○	○	○	○	○
3. Suddenly acting or feeling as if a stressful military experience were happening again (as if you were reliving it)?	○	○	○	○	○
4. Feeling very upset when something reminded you of a stressful military experience?	○	○	○	○	○
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful military experience?	○	○	○	○	○
6. Avoiding thinking about or talking about a stressful military experience or avoiding having feelings related to it?	○	○	○	○	○
7. Avoiding activities or situations becuse they reminded you of a stressful military experience?	○	○	○	○	○
8. Trouble remembering important parts of a stressful military experience?	○	○	○	○	○
9. Loss of interest in things that you used to enjoy?	○	○	○	○	○
10. Feeling distant or cut off from other people?	○	○	○	○	○
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	○	○	○	○	○
12. Feeling as if your future will somehow be cut short?	○	○	○	○	○
13. Trouble falling or staying asleep?	○	○	○	○	○

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C7. HEALTH AND WELLBEING: SLEEP CONDITION

The following questions relate to your usual sleep condition during the past month only.
For each of the questions, colour in the one best response. Please answer all questions.

Thinking about a typical night in the last month ...

1. How long does it take you to fall asleep?

- ○ 0 - 15 minutes
- ○ 16 - 30 minutes
- ○ 31 - 45 minutes
- ○ 46 - 60 minutes
- ○ ≥ 61 minutes

2. If you then wake up during the night **...** how long are you awake for in total? (add all the wakenings up)

- ○ 0 - 15 minutes
- ○ 16 - 30 minutes
- ○ 31 - 45 minutes
- ○ 46 - 60 minutes
- ○ ≥ 61 minutes

3. How many nights a week do you have a problem with your sleep?

- ○ 0 - 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5 - 7

4. How would you rate your sleep quality?

- ○ Very good
- ○ Good
- ○ Average
- ○ Poor
- ○ Very poor

Thinking about the past month, to what extent has poor sleep . . .

5. Affected your mood, energy, or relationships?

- ○ Not at all
- ○ A little
- ○ Somewhat
- ○ Much
- ○ Very much

6. Affected your concentration, productivity, or ability to stay awake?

- ○ Not at all
- ○ A little
- ○ Somewhat
- ○ Much
- ○ Very much

7. Troubles you in general?

- ○ Not at all
- ○ A little
- ○ Somewhat
- ○ Much
- ○ Very much

Finally . . .

8. How long have you had a problem with your sleep?

- ○ I don't have a problem / < 1 mo
- ○ 1 - 2 mo
- ○ 3 - 6 mo
- ○ 7 - 12 mo
- ○ > 1 year

DALLAS PAIN QUESTIONNAIRE

Name_____

Date_____ Date of Injury_____

Please read: This questionnaire has been designed to give your health care provider information as to how your pain affects your daily activities. Be sure that these are your answers. Do not ask someone else to complete this questionnaire for you. Please mark an "X" along the line that expresses your thoughts from 0-100 in each section.

Section I: Pain and Intensity
To what degree do you rely on pain medications or pain relieving substances for you to be comfortable?

None Some All the time
0%(_____:_____:_____:_____:_____:_____)100%

Section II: Personal Care
How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc)?

None(no pain) Some I can't get out of bed
0%(_____:_____:_____:_____:_____:_____)100%

Section III: Lifting
How much limitation do you notice in lifting?

None Some I can't lift anything
0%(_____:_____:_____:_____:_____:_____)100%

Section IV: Walking
Compared to how far you could walk before your injury or back trouble, how much does pain restrict walking now?

The same Almost the same Very little I cannot walk
0%(_____:_____:_____:_____:_____:_____)100%

Section V: Sitting
Back pain limits my sitting in a chair to:

None Some I can't sit at all
0%(_____:_____:_____:_____:_____:_____)100%

Section VI: Standing
How much does pain interfere with your tolerance to stand for long periods?

None(same as before) Some I can't stand
0%(_____:_____:_____:_____:_____:_____)100%

Section VII: Sleeping
How much does pain interfere with your sleeping?

None(same as before) Some I can't sleep at all
0%(_____:_____:_____:_____:_____)100%

Section VIII: Social Life
How much does pain interfere with your social life (dancing, games, going out, eating with friends, etc.)?

None Some No activities
0%(____:____:_____:_____:_____:_____:____:____)100%

Section IX: Traveling
How much does pain interfere with traveling in a car?

None Some I can't travel
0%(_____:_____:_____:_____:_____:_____:_____)100%

Section X: Vocational
How much does pain interfere with your job?

None Some I can't work
0%(____:_____:_____:_____:_____:_____:____:____)100%

Section XI: Anxiety/Mood
How much control do you feel that you have over demands made on you?

Total (no change) Some
None
0%(_____:_____:_____:_____:_____:_____:_____)100%

Section XII: Emotional Control
How much control do you feel you have over your emotions?

Total (no change) Some
None
0%(____:_____:_____:_____:_____:_____:____:____)100%

Section XIII: Depression
How depressed have you been since the onset of pain?

Not depressed significantly Overwhelmed by depression
0%(____:_____:_____:_____:_____:_____:____:____)100%

Section XIV: Interpersonal Relationships
How much do you think your pain has changed your relationships with others?

Not changed Drastically changed
0%(____:_____:_____:_____:_____:_____:____:____)100%

Section XV: Social Support
How much support do you need from others to help you during this onset of pain (taking over chores, meals, etc)?

None needed All the time
0%(_____:_____:_____:_____:_____:_____:____)100%

Section XVI: Punishing Response
How much do you think others express irritation, frustration or anger toward you because of your pain?

None Some All the time
0%(____:_____:_____:_____:_____:_____:____:____)100%

I-VIIx3=_____ VIII-Xx5=_____ XI-XIIIx5=_____ XIV-XVIx5=_____

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C4. HEALTH AND WELLBEING: PSYCHOLOGICAL FLEXIBILITY AND COPING

Below you will find a list of statements. Please rate how true each statement is for you by colouring the appropriate circle.

	Never True	Very Seldom True	Seldom True	Sometimes True	Frequently True	Almost Always True	Always True
1. It's OK if I remember something unpleasant.	○	○	○	○	○	○	○
2. My painful experiences and memories make it difficult for me to live a life that I would value.	○	○	○	○	○	○	○
3. I'm afraid of my feelings.	○	○	○	○	○	○	○
4. I worry about not being able to control my worries and feelings.	○	○	○	○	○	○	○
5. My painful memories prevent me from having a fulfilling life.	○	○	○	○	○	○	○
6. I am in control of my life.	○	○	○	○	○	○	○
7. Emotions cause problems in my life.	○	○	○	○	○	○	○
8. It sems like most people are handling their lives better than I am.	○	○	○	○	○	○	○
9. Worries get in the way of my success.	○	○	○	○	○	○	○
10. My thoughts and feelings get in the way of how I want to live my life.	○	○	○	○	○	○	○