

## Participant Starting Self-Test

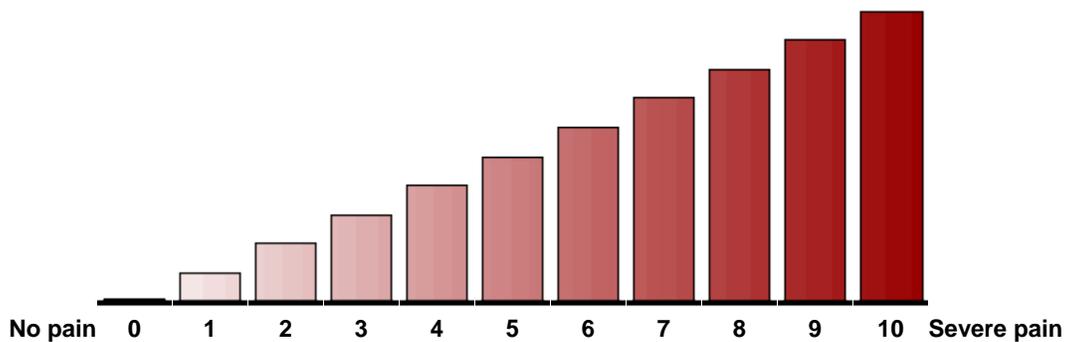
<b>First Name</b>		<b>Last Name</b>	
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Today's Date: \_\_\_\_\_

In general, would you say your health is: <i>(circle one)</i>				
Excellent	Very Good	Good	Fair	Poor

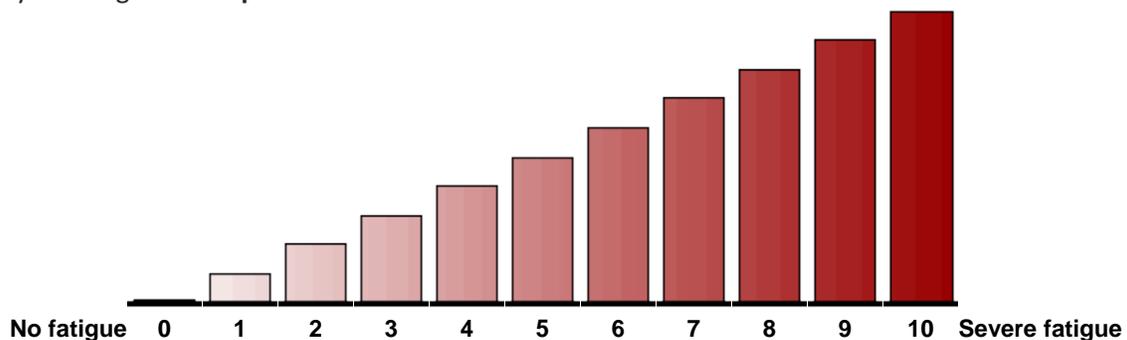
### Pain

We are interested in learning whether or not you are affected by PAIN. Please *circle* the *number* below that describes your pain in the **past 2 weeks**:



### Fatigue

We are interested in learning whether or not you are affected by FATIGUE. Please *circle* the *number* below that describes your fatigue in the **past 2 weeks**:



## Medical Care

1. When you visit your doctor, how often do you do the following (*please circle one number for each question*)

	Never	Almost Never	Some- times	Fairly Often	Very Often	Always
a. Prepare a list of questions for your doctor	0	1	2	3	4	5
b. Ask questions about the things you want to know and things you don't understand about your treatment	0	1	2	3	4	5
c. Discuss any personal problems that may be related to your illness	0	1	2	3	4	5

2. **In the past 6 months**, how many times did you visit a physician? *Do not include visits while in the hospital or the hospital emergency department.* \_\_\_\_\_ visits
3. **In the past 6 months**, how many times did you go to a **hospital** emergency department? \_\_\_\_\_ times
4. **In the past 6 months**, how many TIMES were you hospitalized for one night or longer? \_\_\_\_\_ times
- a. How many total NIGHTS did you spend in the hospital **in the past 6 months**? \_\_\_\_\_ nights
- b. Were any of these hospitalizations at a skilled nursing facility, convalescent hospital, or other minimum care facility? (*circle one*)      Yes      No

## Exercise

**During the past week**, even if it was **not** a typical week, how much **total** time (*for the entire week*) did you spend on each of the following? (*Please circle one number of each activity.*)

<i>Exercises</i>	<i>None</i>	<i>Less than 30 min/week</i>	<i>30 – 60 min/week</i>	<i>1 – 3 hrs/week</i>	<i>More than 3 hrs/week</i>
1. Stretching or strengthening exercises (range of motion, using weights, etc.)	0	1	2	3	4
2. Walk for exercise	0	1	2	3	4
3. Swimming or aquatic exercise	0	1	2	3	4
4. Bicycling (including stationary exercise bike)	0	1	2	3	4
5. Other aerobic equipment (elliptical machine, rowing or skiing machine)	0	1	2	3	4
6. Other aerobic exercise	0	1	2	3	4

## Confidence About Doing Things

For each of the following questions, please **circle** the number that corresponds with your **confidence** that you can do the tasks regularly at the present time.

<i>How confident are you that you can...</i>	<i>Not at all Confident</i>										<i>Totally Confident</i>									
1. Keep the fatigue caused by your disease from interfering with the things you want to do?	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
2. Keep the physical discomfort or pain of your disease from interfering with the things you want to do?	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
3. Keep the emotional distress caused by your disease from interfering with the things you want to do?	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
4. Keep any other symptoms or health problems you have from interfering with the things you want to do?	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
5. Do the different tasks and activities needed to manage your health conditions so as to reduce your need to see a doctor?	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
6. Do things other than just taking medication to reduce how much your illness affects your everyday life?	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10