Patient Name: _____ Date: _____

Multi-Dimensional Health Assessment Questionnaire (R791-NP2)

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. **There are no right or wrong answers**. Please answer exactly as you think you feel. Thank you.

1. Please check the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** To Do
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car, bus, train, or airplane?	0	1	2	3
i. Walk two miles or three kilometers, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	1	2	3
k. Get a good night's sleep?	0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
m. Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

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1. FN (0-10)

1-0.3	16-5.3
2-0.7	17-5.7
3-1.0	18-6.0
4-1.3	19-6.3
5-1.7	20-6.7
6-2.0	21-7.0
7-2.3	22-7.3
8-2.7	23-7.7
9-3.0	24-8.0
10-3.3	25-8.3
11-3.7	26-8.7
12-4.0	27-9.0
13-4.3	28-9.3
14-4.7	29-9.7
15-5.0	30-10

2. PN (0-10)

3. PTGL (0-10)

RAPID 3(0-30)

2. How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe you pain has been:

NO PAIN ○ PAIN AS BAD AS IT COULD BE

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

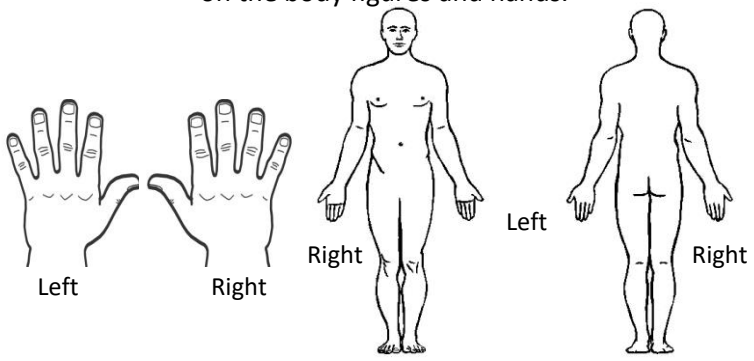
3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL ○ VERY POORLY

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

FLIP OVER

Please **shade** all the locations of your pain over the past week on the body figures and hands.



What is your primary concern you wish to discuss with the physician today?

_____

Please **circle** if you are experiencing the following:

Fevers	Night Sweats
Unexplained weight loss	Weight gain
Chest pain	Cough (chronic)
Mouth sores/ulcers	Breathing difficulty
Abdominal Pain	Diarrhea
Skin rash	Recent Infection

Medication List

Thank you for allowing us to participate in your care today!

Please fill out the medication list below so we can make sure that everything is up to date in your chart. If you don't know how to spell something correctly just try your best! Please list the medications that we provide you on top of the list. Effective today we will no longer be providing refills in between appointments, we will provide you with enough refills today to get you to your next appointment. (Unless otherwise indicated by your provider)

Medication	Dose & How it is taken	Qty Requested