The following questions reflect upon your feeling and abilities over the past 4 weeks.

1. What was the hardest physical activity you could do for at least 2 minutes?
   - Very heavy (run/fast pace, carry heavy loads uphill)
   - Heavy (jog/slow pace, climb stairs or hill)
   - Moderate (walk/medium pace, carry heavy loads on level ground)
   - Light (walk/medium pace, carry light loads on level ground)
   - Very light (walk/slow pace, wash dishes)

2. How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or downhearted and blue?
   - Not at all
   - Slightly
   - Moderately
   - Quite a bit
   - Extremely

3. How much difficulty have you had doing your usual activities or tasks both inside and outside the house because of your physical and emotional health?
   - No difficulty
   - A little bit of difficulty
   - Some difficulty
   - Much difficulty
   - Could not do

4. Has your physical and emotional health limited your social activities with family, friends, neighbors or groups?
   - Not at all
   - Slightly
   - Moderately
   - Quite a bit
   - Extremely

5. How much bodily pain have you generally had?
   - No pain
   - Very mild pain
   - Mild pain
   - Moderate pain
   - Severe pain

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6. How would you rate your overall health now compared to 4 weeks ago?
   - Much better
   - A little better
   - About the same
   - A little worse
   - Much worse

7. How would you rate your health in general?
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

8. Was someone available to help you if you needed and wanted help?
   - Yes, as much as I wanted
   - Yes, quite a bit
   - Yes, some
   - Yes, a little
   - No, not at all

9. How have things been going for you during the past 4 weeks?
   - Very well - could hardly be better
   - Pretty good
   - Good and bad parts about equal
   - Pretty bad
   - Very bad - could hardly be worse

Score: ________________

Patient (signature): __________________________ Date: _______ Time: _______

If patient is unable to complete:

Completed by (signature): __________________________ Date: _______ Time: _______
Completed by (print name): __________________________ Relationship to Patient: _______

Clinician (signature): __________________________ Date: _______ Time: _______
Clinician (print name): __________________________

Interpreter Information (To be completed by Inova staff, if applicable):
   - In person
   - Telephonic
   - Video
   - Interpreter name/ID number (if applicable)
   - Patient/Designated Decision Maker was offered and refused interpreter
   - Waiver signed