



Initial Assessment
 _____ - Day Reassessment
 Discharge

The following question 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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PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: Male Female

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IAH
 IFH
 IFOH
 ILH
 IMVH

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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): _____

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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

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