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| **Name: Patient ID: Date:** |

This questionnaire is about your joint, back, neck, bone and muscle symptoms such as aches, pains and/or stiffness. Please focus on the particular health problem(s) for which you sought treatment from this service. For each question tick () **ONE** box to indicate which statement best describes you over the last 2 weeks.

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| --- | --- | --- | --- | --- | --- |
|  | 4 | 3 | 2 | 1 | 0 |
| 1. **Pain/stiffness** during the dayHow severe was your usual joint ormuscle pain and/or stiffness overallduring the day in the last 2 weeks? | Not all all | Slightly | Moderately | Fairly severely | Very severe |
| **2. Pain/stiffness** during the nightHow severe was your usual joint ormuscle pain and/or stiffness overallduring the night in the last 2 weeks? | Not all all | Slightly | Moderately | Fairly severely | Very severe |
| **3. Walking** - How much have your symptoms interfered with your ability to walk in the last 2 weeks? | Not all all | Slightly | Moderately | Severely | Unable to walk |
| **4. Washing/Dressing**How much have your symptomsinterfered with your ability to wash or dress yourself in the last 2 weeks? | Not all all | Slightly | Moderately | Severely | Unable to wash or dress myself |
| **5. Physical activity levels** How much has it been a problem foryou to do physical activities (e.g. going for a walk or jogging) to the level you want because of your joint or muscle symptoms in the last 2 weeks? | Not at all | Slightly | Moderately | Very much | Unable to do physical activities |
| **6. Work/daily routine**How much have your joint or musclesymptoms interfered with your work or daily routine in the last 2 weeks(including work & jobs around thehouse)? | Not all all | Slightly | Moderately | Severely | Extremely |
| **7. Social activities and hobbies**How much have your joint or musclesymptoms interfered with your social activities and hobbies in the last 2 weeks? | Not all all | Slightly | Moderately | Severely | Extremely |
|  | **4** | **3** | **2** | **1** | **0** |
| **8. Needing help** How often have you needed help from others (including family, friends or carers) because of your joint or muscle symptoms in the last 2 weeks?  | Not all all | Rarely | Sometimes | Frequently | All the time |
| **9. Sleep** How often have you had trouble with either falling asleep or staying asleep because of your joint or muscle symptoms in the last 2 weeks?  | Not all all | Rarely | Sometimes | Frequently | Every night |
| **10. Fatigue or low energy** How much fatigue or low energy have you felt in the last 2 weeks?  | Not at all | Slight | Moderate | Severe | Extreme |
| **11.** **Emotional well-being** How much have you felt anxious or low in your mood because of your joint or muscle symptoms in the last 2 weeks?  | Not at all | Slightly | Moderately | Severely | Extremely |
| **12.** **Understanding of your condition and any current treatment** Thinking about your joint or muscle symptoms, how well do you feel you understand your condition and any current treatment (including your diagnosis and medication)?  | Completely | Very well | Moderately | Slightly | Not at all |
| **13. Confidence in being able to manage your symptoms** How confident have you felt in being able to manage your joint or muscle symptoms by yourself in the last 2 weeks (e.g. medication, changing lifestyle)?  | Extremely | Very | Moderately | Slightly | Not at all |
| **14. Overall impact** How much have your joint or muscle symptoms bothered you overall in the last 2 weeks? | Not all all | Slightly | Moderately | Very much | Extremely |

Physical activity levels In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your heart rate? This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that is part of your job.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| None | 1 day | 2 day | 3 day | 4 day | 5 day | 6 day | 7 days |

Please fill in this form at the beginning and end of your treatment

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| --- | --- | --- | --- | --- | --- |
|  | 4 | 3 | 2 | 1 | 0 |
| 1. How likely would you be to recommend the service to your friends and family | Very likely  | likely | Unsure  | Not likely | Very unlikely |
| 2. After your assessment did you have a better understanding of what your problem is? | Yes |  |  |  | No |
| **3.** How satisfied were you with the service | completely | Mostly satisfied  | Moderately | Unsatisfied  | Very unsatisfied |
| **4.** Were the physiofit team considerate and professional at all times?  | Yes |  |  |  | No |
| **5.** Did you receive a discharge plan with self-care advice included? | Yes |  |  |  | No |

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| If you have any other comments or suggestions, please add them below |
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| If you were particularly happy with your treatment and would like to leave a compliment or testimonial, please do so below. |
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