Musculoskeletal Function Assessment

We would like you to answer the questions in this survey based on your condition before your injury.

Please answer "YES" or "NO" to each question by putting a check in the box □ next to the question. If the question was true for you before your injury, choose "YES". If the question was not true for you before your injury, choose "NO".

If you wish to comment on any of the questions, please use the space in the margins. Please answer all questions, even though some of the questions may not seem to apply to you.

**ACTIVITIES USING YOUR ARMS OR LEGS**

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| This first set of questions is about using your arms or legs to do such things as reaching, walking, and carrying. ***Before your injury . . .*** |
| 1. Were you able to walk? | □ Yes | □ No |
| 2. Did you feel unsteady on your feet? | □ Yes | □ No |
| 3. Was it difficult for you to reach up high? | □ Yes | □ No |
| 4. Did you straighten or bend your arm(s) completely? | □ Yes | □ No |
| 5. Did you straighten or bend your leg(s) completely? | □ Yes | □ No |
| 6. Did you pivot? | □ Yes | □ No |
| 7. Did you climb up and down ladders? | □ Yes | □ No |
| 8. Did you have to rest often when walking? | □ Yes | □ No |
| 9. Did you avoid stairs? | □ Yes | □ No |
| 10. Did you stand for long periods of time? | □ Yes | □ No |
| 11. Was it hard for you to get moving after you’d been sitting or lying down? | □ Yes | □ No |
| 12. Did you always walk with a limp? | □ Yes | □ No |
| 13. Did you leg sometimes lock or give-way? | □ Yes | □ No |
| 14. Did you have trouble getting in or out of a low chair? | □ Yes | □ No |
| 15. Did you have trouble getting in or out of bed? | □ Yes | □ No |
| 16. Did you kneel? | □ Yes | □ No |
| 17. Did you pick up things from the floor? | □ Yes | □ No |
| 18. Did you run at all? | □ Yes | □ No |
| 19. Did you have trouble getting in or out of a car? | □ Yes | □ No |
| 20. Had you stopped using public transportation because of your physical condition? | □ Yes | □ No |

Before your injury, how much were you bothered by problems using your arms or legs?

*(Please check one)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| □ 1Not atall bothered | □ 2A littlebothered | □ 3Somewhat bothered | □ 4Quitebothered | □ 5Extremelybothered |

**ACTIVITIES USING YOUR HANDS**

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| The following questions are about activities using your hands. ***Before your injury . . .*** |
| 1. Did you have difficulty squeezing things? | □ Yes | □ No |
| 2. Could you make a tight fist? | □ Yes | □ No |
| 3. Was it hard for you to put your hand in your pocket? | □ Yes | □ No |
| 4. Did you have difficulty turning knobs or levers (for example, opening doors, rolling down car windows)? | □ Yes | □ No |
| 5. Did you have trouble holding a book? | □ Yes | □ No |
| 6. Did you have difficulty writing or typing? | □ Yes | □ No |
| 7. Did you have trouble opening medicine bottles or jars? | □ Yes | □ No |

Before your injury, how much were you bothered by problems using your hands? *(Please check one)*

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| □ 1Not atall bothered | □ 2A littlebothered | □ 3Somewhat bothered | □ 4Quitebothered | □ 5Extremelybothered |

**WORK AROUND YOUR HOME**

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| These questions are about activities around your home, including such things as cooking, cleaning, maintenance, or repairs. ***Before your injury . . .*** |
| 1. Did you need help with housework or yard work? | □ Yes | □ No |
| 2. Did you do as much housework or yard work as you wanted? | □ Yes | □ No |
| 3. Was it difficult for you to do household chores because they took so much effort? | □ Yes | □ No |
| 4. Did you mop or sweep or vacuum? | □ Yes | □ No |
| 5. Was scrubbing a pan or dish difficult? | □ Yes | □ No |
| 6. Did you need someone to cook for you? | □ Yes | □ No |
| 7. Did it take you a long time to do household chores? | □ Yes | □ No |
| 8. Was it difficult for you to shop for groceries or other thing? | □ Yes | □ No |
| 9. Had you stopped doing car, house, or maintenance repairs because of your physical condition? | □ Yes | □ No |

Before your injury, how much were you bothered by problems doing work around your home? *(Please check one)*

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| --- | --- | --- | --- | --- |
| □ 1Not atall bothered | □ 2A littlebothered | □ 3Somewhat bothered | □ 4Quitebothered | □ 5Extremelybothered |

**SELF CARE ACTIVITIES**

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| The following questions are about taking care of yourself. ***Before your injury . . .*** |
| 1. Did you wear things that were easier to get into? | □ Yes | □ No |
| 2. Did you sometimes need help from others to get dressed? | □ Yes | □ No |
| 3. Did you struggle with buttons, snaps, hooks, zippers? | □ Yes | □ No |
| 4. Did you have trouble pulling clothes on over your head? | □ Yes | □ No |
| 5. Was it difficult for you to put on shoes, socks, or stockings? | □ Yes | □ No |
| 6. Was it a chore for you to dress because it took so long? | □ Yes | □ No |
| 7. Was it difficult to brush your teeth? | □ Yes | □ No |
| 8. Did you have a difficult time cutting your fingernails? | □ Yes | □ No |
| 9. Did you need help keeping yourself clean after going to the bathroom? | □ Yes | □ No |
| 10. Was it difficult for you to get on or off the toilet? | □ Yes | □ No |
| 11. Was it hard for you to get in or out of the bathtub or shower? | □ Yes | □ No |
| 12. Did you sit while showering? | □ Yes | □ No |
| 13. Did you need help washing yourself? | □ Yes | □ No |
| 14. Did you need help eating? | □ Yes | □ No |
| 15. Was it hard for you to cut food? | □ Yes | □ No |
| 16. Were you stuck at home because of your physical condition? | □ Yes | □ No |
| 17. Had you stopped going out by yourself? | □ Yes | □ No |
| 18. Had you stopped driving because of your physical condition? | □ Yes | □ No |

Before your injury, how much were you bothered by problems caring for yourself? *(Please check one)*

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| □ 1Not atall bothered | □ 2A littlebothered | □ 3Somewhat bothered | □ 4Quitebothered | □ 5Extremelybothered |

**SLEEP AND REST**

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| These questions are about changes or problems you may have experienced with sleep and rest. ***Before your injury . . .*** |
| 1. Were you tired all of the time? | □ Yes | □ No |
| 2. Did you have trouble falling asleep at night? | □ Yes | □ No |
| 3. Did you have difficulty sleeping the whole night? | □ Yes | □ No |
| 4. Was it hard for you to get comfortable to sleep? | □ Yes | □ No |
| 5. Did you wake up sooner than you would like? | □ Yes | □ No |
| 6. Did you have disturbing dreams? | □ Yes | □ No |

Before you injury, how much were you bothered by problems with sleep and rest? *(Please check one)*

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| --- | --- | --- | --- | --- |
| □ 1Not atall bothered | □ 2A littlebothered | □ 3Somewhat bothered | □ 4Quitebothered | □ 5Extremelybothered |

**LEISURE and RECREATIONAL ACTIVITIES**

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| The following questions are about changes or problems you may have had before your injury with leisure time or recreational activities. These activities may include such things as hobbies, sports, crafts, gardening, aerobics, or volunteering. ***Before your injury . . .*** |
| 1. Was your physical fitness worse because of your health or physical condition? | □ Yes | □ No |
| 2. Did you do **less** of your usual physical recreational activities because of your health or physical condition? | □ Yes | □ No |
| 3. Had you stopped doing **all** of your usual physical recreational activities? | □ Yes | □ No |
| 4. Were you doing fewer leisure activities (such as hobbies, crafts, gardening, card playing, going out with friends) because of your health or physical condition? | □ Yes | □ No |

Before your injury, how much were you bothered by problems doing leisure and recreational activities? *(Please check one)*

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| □ 1Not atall bothered | □ 2A littlebothered | □ 3Somewhat bothered | □ 4Quitebothered | □ 5Extremelybothered |

**RELATIONSHIPS: FAMILY and FRIENDS**

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| These questions are about your relationships with family, friends, and other important people in your life. ***Before your injury . . .*** |
| 1. Was there a strain in your relationships with either your friends or family? | □ Yes | □ No |
| 2. Did you feel you just didn’t want to be around anybody? | □ Yes | □ No |
| 3. Was it hard for you to get either your family or friends to help you do things? | □ Yes | □ No |
| 4. Were you lonely? | □ Yes | □ No |
| 5. Did you feel that either your friends or family had shied away from you? | □ Yes | □ No |
| 6. Did you often act irritable towards those around you (for example, snap at people, give sharp answers, criticize easily)? | □ Yes | □ No |
| 7. Did you miss being with either your friends or family? | □ Yes | □ No |
| 8. Did you feel like being less intimate because of your physical condition? | □ Yes | □ No |
| 9. Had your sexual life changed because of your physical condition? | □ Yes | □ No |
| 10. Did you enjoy sex less because of your physical condition? | □ Yes | □ No |

Before your injury, how much were you bothered by problems you had with your friends, family, and other important people in your life? *(Please check one)*

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**THINKING**

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| These questions are about thinking, concentrating, or remembering. ***Before your injury . . .*** |
| 1. Did it take you a long time to figure things out? | □ Yes | □ No |
| 2. Did you have problems with concentration? | □ Yes | □ No |
| 3. Were you confused and scattered? | □ Yes | □ No |
| 4. Were you forgetful? | □ Yes | □ No |

Before your injury, how much were you bothered by problems with thinking, concentrating, and remembering?  *(Please check one)*

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| --- | --- | --- | --- | --- |
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**LIFE CHANGES and FEELINGS**

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| The following questions are about the day to day adjustments and feelings you may have been experiencing in your life before your injury. ***Before your injury . . .*** |
| 1. Did you sometimes use your physical condition as an excuse not to do things? | □ Yes | □ No |
| 2. Did you have to concentrate when using your hands, arms, legs, or feet? | □ Yes | □ No |
| 3. Did you avoid using your hands, arms, legs, or feet? | □ Yes | □ No |
| 4. Did you protect your hands, arms, legs, or feet? | □ Yes | □ No |
| 5. Did you accept you physical condition? | □ Yes | □ No |
| 6. Did you feel your life had changed because of your health or physical condition? | □ Yes | □ No |
| 7. Did you feel your physical condition was getting worse over time? | □ Yes | □ No |
| 8. If you did too much in one day, did it affect what you did the next day? | □ Yes | □ No |
| 9. Did you feel disabled, even though you may have looked fine to others? | □ Yes | □ No |
| 10. Did you feel useless? | □ Yes | □ No |
| 11. Did you feel unattractive? | □ Yes | □ No |
| 12. Did your physical condition make you feel less capable? | □ Yes | □ No |
| 13. Did you feel sorry for yourself? | □ Yes | □ No |
| 14. Did you feel like you complained a lot? | □ Yes | □ No |
| 15. Did you have to ask for help a lot? | □ Yes | □ No |
| 16. Did you feel angry or frustrated about your health or any physical condition? | □ Yes | □ No |

Before your injury, how much were you bothered by the day to day adjustments you were making and the feelings you were experiencing in your life?

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| --- | --- | --- | --- | --- |
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**WORK ACTIVITIES**

Were you working before you injury?

 □ No……Were you unable to work because of your health or physical condition?

 □No

 □Yes

 □Yes…… (Please answer the questions below)

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| Please answer these questions as they describe your experiences at work before your injury. ***Before your injury . . .*** |
| 1. Were you making changes in your job? | □ Yes | □ No |
| 2. Was it more difficult for you to do your job because of your health or physical condition? | □ Yes | □ No |
| 3. Were you slow at your job because of your health or physical condition? | □ Yes | □ No |
| 4. Did you take more breaks because of your health or physical condition? | □ Yes | □ No |

Before your injury, how much were you bothered by problems with work activities, because of your physical condition? (Please check one)

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| --- | --- | --- | --- | --- |
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