

RAPID 3/ Multi Dimensional HAO

Name : _____

Date : _____

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 or 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 <u>Difficulty</u>	With SOME Difficulty	With MUCH Difficulty	UNABLE <u>To Do</u>
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- | | Difficulty | Difficulty | Difficulty | Difficulty |
|--|------------|------------|------------|------------|
| 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 |

2. How much pain have you had because of your condition OVER THE PAST WEEK?

Please indicate below how severe your pain has been:

[illegible]

3. Please place a check (✓) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
<u>a. LEFT FINGERS</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<u>i. RIGHT FINGERS</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<u>b. LEFT WRIST</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<u>j. RIGHT WRIST</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<u>c. LEFT ELBOW</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<u>k. RIGHT ELBOW</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<u>d. LEFT SHOULDER</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<u>l. RIGHT SHOULDER</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<u>e. LEFT HIP</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<u>m. RIGHT HIP</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<u>f. LEFT KNEE</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<u>n. RIGHT KNEE</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<u>g. LEFT ANKLE</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<u>o. RIGHT ANKLE</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<u>h. LEFT TOES</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<u>p. RIGHT TOES</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<u>q. NECK</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<u>r. BACK</u>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

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

[illegible]

**FOR OFFICE
USE ONLY**

15-111 FN(0-10)



Q

1990

1-03	16-33
1-04	17-57

3=1.0	18=6.0
4=1.3	19=6.3

$5 = 17$ $20 = 67$
 $6 = 20$ $21 = 70$


$$\begin{array}{l} 7=2 \cdot 3+1, \quad 2=3-1 \\ 8=2 \cdot 7-6, \quad 2=7-5 \end{array}$$

2=3.0	246.0
10=3.3	236.3

$$\begin{array}{l} 11-3=7 \quad 26=8-7 \\ 12-4=8 \quad 27=9-8 \end{array}$$
$$\begin{array}{r} 13 \times 4 = 52 \\ 14 \times 7 = 98 \end{array}$$

1330 10 10

2PN (0-10)



一

140

4. **PLATE (0-10)**

2014

110

RAPID 3 (0:30)

14		15
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<input type="checkbox"/> Fever	<input type="checkbox"/> Lump in your throat	<input type="checkbox"/> Paralysis of arms or legs
<input type="checkbox"/> Weight gain (>10 lbs)	<input type="checkbox"/> Cough	<input type="checkbox"/> Numbness or tingling of arms or legs
<input type="checkbox"/> Weight loss (<10 lbs)	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Fainting spells
<input type="checkbox"/> Feeling sickly	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Swelling of hands
<input type="checkbox"/> Headaches	<input type="checkbox"/> Pain in the chest	<input type="checkbox"/> Swelling of ankles
<input type="checkbox"/> Unusual fatigue	<input type="checkbox"/> Heart pounding (palpitations)	<input type="checkbox"/> Swelling in other joints
<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Heartburn or stomach gas	<input type="checkbox"/> Back pain
<input type="checkbox"/> Skin rash or hives	<input type="checkbox"/> Stomach pain or cramps	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Unusual bruising or bleeding	<input type="checkbox"/> Nausea	<input type="checkbox"/> Use of drugs not sold in stores
<input type="checkbox"/> Other skin problems	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Smoking cigarettes
<input type="checkbox"/> Loss of hair	<input type="checkbox"/> Constipation	<input type="checkbox"/> More than 2 alcoholic drinks per day
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Depression - feeling blue
<input type="checkbox"/> Other eye problems	<input type="checkbox"/> Dark or bloody stools	<input type="checkbox"/> Anxiety - feeling nervous
<input type="checkbox"/> Problems with hearing	<input type="checkbox"/> Problems with urination	<input type="checkbox"/> Problems with thinking
<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Gynecological (female) problems	<input type="checkbox"/> Problems with memory
<input type="checkbox"/> Stuffy nose	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Problems with sleeping
<input type="checkbox"/> Sores in the mouth	<input type="checkbox"/> Losing your balance	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Muscle pain, aches, or cramps	<input type="checkbox"/> Burning in sex organs
<input type="checkbox"/> Problems with smell or taste	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Problems with social activities

7. How do you feel TODAY compared to ONE WEEK AGO? Please check (✓) only one.
Much Better - (1), Better - (2), the Same - (3), Worse - (4), Much Worse - (5) than one week ago

9. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

FATIGUE IS NO PROBLEM 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 FATIGUE IS A MAJOR PROBLEM

SIGNATURE _____ **Date:** _____ **Page**2/2