



Quality of Life Questionnaire

Qualeffo-41

Users of this questionnaire (and all authorized translations) must adhere to the user agreement. Please use the related Scoring Algorithm.

A Pain	
<i>The five questions in this section regard the situation in the last week.</i>	
How often have you had back pain in the last week?	<input type="checkbox"/> never <input type="checkbox"/> 1 day per week or less <input type="checkbox"/> 2-3 days per week <input type="checkbox"/> 4-6 days per week <input type="checkbox"/> every day
If you have had back pain, for how long did you have back pain in the daytime?	<input type="checkbox"/> never <input type="checkbox"/> 1-2 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 6-10 hours <input type="checkbox"/> all day
How severe is your back pain at its worst?	<input type="checkbox"/> no back pain <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> unbearable
How is your back pain at other times?	<input type="checkbox"/> no back pain <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> unbearable
Has the back pain disturbed your sleep in the last week?	<input type="checkbox"/> less than once per week <input type="checkbox"/> once a week <input type="checkbox"/> twice a week <input type="checkbox"/> every other night <input type="checkbox"/> every night

B Activities of Daily Living

The next 4 questions regard the situation at present.

Do you have problems with dressing?	<input type="checkbox"/> no difficulty <input type="checkbox"/> a little difficulty <input type="checkbox"/> moderate difficulty <input type="checkbox"/> may need some help <input type="checkbox"/> impossible without help
Do you have problems with taking a bath or shower?	<input type="checkbox"/> no difficulty <input type="checkbox"/> a little difficulty <input type="checkbox"/> moderate difficulty <input type="checkbox"/> may need some help <input type="checkbox"/> impossible without help
Do you have problems with getting to or operating a toilet?	<input type="checkbox"/> no difficulty <input type="checkbox"/> a little difficulty <input type="checkbox"/> moderate difficulty <input type="checkbox"/> may need some help <input type="checkbox"/> impossible without help
How well do you sleep?	<input type="checkbox"/> sleep undisturbed <input type="checkbox"/> wake up sometimes <input type="checkbox"/> wake up often <input type="checkbox"/> sometimes I lie awake for hours <input type="checkbox"/> sometimes I have a sleepless night

C Jobs Around the House

The next 5 questions are concerned with the present situation. If someone else does these things in your house, please answer as though you were responsible for them.

Can you do the cleaning?	<input type="checkbox"/> without difficulty <input type="checkbox"/> with a little difficulty <input type="checkbox"/> with moderate difficulty <input type="checkbox"/> with great difficulty <input type="checkbox"/> impossible
Can you prepare meals?	<input type="checkbox"/> without difficulty <input type="checkbox"/> with a little difficulty <input type="checkbox"/> with moderate difficulty <input type="checkbox"/> with great difficulty <input type="checkbox"/> impossible

Can you wash the dishes?	<input type="checkbox"/> without difficulty <input type="checkbox"/> with a little difficulty <input type="checkbox"/> with moderate difficulty <input type="checkbox"/> with great difficulty <input type="checkbox"/> impossible
Can you do your day to day shopping?	<input type="checkbox"/> without difficulty <input type="checkbox"/> with a little difficulty <input type="checkbox"/> with moderate difficulty <input type="checkbox"/> with great difficulty <input type="checkbox"/> impossible
Can you lift a heavy object of 20 lbs (e.g. a crate of 12 bottles of milk, or a one year old child) and carry it for at least 10 yards?	<input type="checkbox"/> without difficulty <input type="checkbox"/> with a little difficulty <input type="checkbox"/> with moderate difficulty <input type="checkbox"/> with great difficulty <input type="checkbox"/> impossible

D Mobility

The next 8 questions also regard the present situation.

Can you get up from a chair?	<input type="checkbox"/> without difficulty <input type="checkbox"/> with a little difficulty <input type="checkbox"/> with moderate difficulty <input type="checkbox"/> with great difficulty <input type="checkbox"/> only with help
Can you bend down?	<input type="checkbox"/> easily <input type="checkbox"/> fairly easily <input type="checkbox"/> moderately <input type="checkbox"/> very little <input type="checkbox"/> impossible
Can you kneel down?	<input type="checkbox"/> easily <input type="checkbox"/> fairly easily <input type="checkbox"/> moderately <input type="checkbox"/> very little <input type="checkbox"/> impossible
Can you climb stairs to the next floor of a house?	<input type="checkbox"/> without difficulty <input type="checkbox"/> with a little difficulty <input type="checkbox"/> with at least one rest

	<input type="checkbox"/> only with help <input type="checkbox"/> impossible
Can you walk 100 yards?	<input type="checkbox"/> fast without stopping <input type="checkbox"/> slowly without stopping <input type="checkbox"/> slowly with at least one stop <input type="checkbox"/> only with help <input type="checkbox"/> impossible
How often have you been outside in the last week?	<input type="checkbox"/> every day <input type="checkbox"/> 5-6 days/week <input type="checkbox"/> 3-4 days/week <input type="checkbox"/> 1-2 days/week <input type="checkbox"/> less than once/week
Can you use public transportation?	<input type="checkbox"/> without difficulty <input type="checkbox"/> with a little difficulty <input type="checkbox"/> with moderate difficulty <input type="checkbox"/> with great difficulty <input type="checkbox"/> only with help
Have you been affected by the changes of your figure due to osteoporosis (for example loss of height, increase of waist measurement, shape of your back)?	<input type="checkbox"/> not at all <input type="checkbox"/> a little <input type="checkbox"/> moderately <input type="checkbox"/> quite a bit <input type="checkbox"/> very much

E Leisure, Social Activities

Do you play any sports now?	<input type="checkbox"/> yes <input type="checkbox"/> yes with restrictions <input type="checkbox"/> not at all
Can you do your gardening?	<input type="checkbox"/> yes <input type="checkbox"/> yes with restrictions <input type="checkbox"/> not at all <input type="checkbox"/> not applicable
Do you participate in any hobbies now?	<input type="checkbox"/> yes <input type="checkbox"/> yes with restrictions <input type="checkbox"/> not at all

Can you visit a cinema, theatre, etc.?	<input type="checkbox"/> yes <input type="checkbox"/> yes with restrictions <input type="checkbox"/> not at all <input type="checkbox"/> no cinema, or theater within a reasonable distance
How often did you visit friends or relatives during the last 3 months?	<input type="checkbox"/> once a week or more <input type="checkbox"/> once or twice a month <input type="checkbox"/> less than once a month <input type="checkbox"/> never
How often did you participate in social activities (clubs, social gatherings, church activities, charity etc.) during the last 3 months?	<input type="checkbox"/> once a week or more <input type="checkbox"/> once or twice a month <input type="checkbox"/> less than once a month <input type="checkbox"/> never
Does your back pain or disability interfere with intimacy (including sexual activity)?	<input type="checkbox"/> not at all <input type="checkbox"/> a little <input type="checkbox"/> moderately <input type="checkbox"/> severely <input type="checkbox"/> not applicable

F General Health Perception

For your age, in general, would you say your health is:	<input type="checkbox"/> excellent <input type="checkbox"/> good <input type="checkbox"/> satisfactory <input type="checkbox"/> fair <input type="checkbox"/> poor
How would you rate your overall quality of life during the last week?	<input type="checkbox"/> excellent <input type="checkbox"/> good <input type="checkbox"/> satisfactory <input type="checkbox"/> fair <input type="checkbox"/> poor
How would you rate your overall quality of life compared with 10 years ago?	<input type="checkbox"/> much better now <input type="checkbox"/> slightly better now <input type="checkbox"/> unchanged <input type="checkbox"/> slightly worse now <input type="checkbox"/> much worse now

G Mental Function

The next nine questions regard the situation in the last week.

Do you tend to feel tired?	<input type="checkbox"/> in the morning <input type="checkbox"/> in the afternoon <input type="checkbox"/> only in the evening <input type="checkbox"/> after strenuous activity <input type="checkbox"/> almost never
Do you feel downhearted?	<input type="checkbox"/> almost every day <input type="checkbox"/> three to five days a week <input type="checkbox"/> one or two days a week <input type="checkbox"/> once in a while <input type="checkbox"/> almost never
Do you feel lonely?	<input type="checkbox"/> almost every day <input type="checkbox"/> three to five days a week <input type="checkbox"/> one or two days a week <input type="checkbox"/> once in a while <input type="checkbox"/> almost never
Do you feel full of energy?	<input type="checkbox"/> almost every day <input type="checkbox"/> three to five days a week <input type="checkbox"/> one or two days a week <input type="checkbox"/> once in a while <input type="checkbox"/> almost never
Are you hopeful about your future?	<input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> sometimes <input type="checkbox"/> quite often <input type="checkbox"/> always
Do you get upset over little things?	<input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> sometimes <input type="checkbox"/> quite often <input type="checkbox"/> always
Do you find it easy to make contact with people?	<input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> sometimes <input type="checkbox"/> quite often <input type="checkbox"/> always

Are you in good spirits most of the day?	<input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> sometimes <input type="checkbox"/> quite often <input type="checkbox"/> always
Are you afraid of becoming totally dependent?	<input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> sometimes <input type="checkbox"/> quite often <input type="checkbox"/> always