

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>	
1 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
2 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
3 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
4 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
5 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.

6 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
7 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
8 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
9 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.

10 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
11 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

<p>12 Can you wash the dishes?</p>	<ul style="list-style-type: none"> <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
<p>13 Can you do your day to day shopping?</p>	<ul style="list-style-type: none"> <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
<p>14 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?</p>	<ul style="list-style-type: none"> <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.

<p>15 Can you get up from a chair?</p>	<ul style="list-style-type: none"> <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
<p>16 Can you bend down?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> easily <input type="checkbox"/> fairly easily <input type="checkbox"/> moderately <input type="checkbox"/> very little <input type="checkbox"/> impossible
<p>17 Can you kneel down?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> easily <input type="checkbox"/> fairly easily <input type="checkbox"/> moderately <input type="checkbox"/> very little <input type="checkbox"/> impossible
<p>18 Can you climb stairs to the next floor of a house?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> without difficulty <input type="checkbox"/> with a little difficulty <input type="checkbox"/> with at least one rest

	<input type="checkbox"/> with great difficulty <input type="checkbox"/> impossible
19 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
20 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
21 Can you use public transport?	<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
22 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

23 Do you play any sport now?	<input type="checkbox"/> yes <input type="checkbox"/> yes with restrictions <input type="checkbox"/> not at all
24 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
25 Do you perform any hobby now?	<input type="checkbox"/> yes <input type="checkbox"/> yes with restrictions <input type="checkbox"/> not at all

<p>26 Can you visit a cinema, theatre, etc.?</p>	<p><input type="checkbox"/> yes <input type="checkbox"/> yes with restrictions <input type="checkbox"/> not at all <input type="checkbox"/> no cinema, or theatre within a reasonable distance</p>
<p>27 How often did you visit friends or relatives during the last 3 months?</p>	<p><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</p>
<p>28 How often did you participate in social activities (clubs, social gatherings, church activities, charity etc.) during the last 3 months?</p>	<p><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</p>
<p>29 Does your back pain or disability interfere with intimacy (including sexual activity)?</p>	<p><input type="checkbox"/> not at all <input type="checkbox"/> a little <input type="checkbox"/> moderately <input type="checkbox"/> severely <input type="checkbox"/> not applicable</p>

F General Health Perception

<p>30 For your age, in general, would you say your health is:</p>	<p><input type="checkbox"/> excellent <input type="checkbox"/> good <input type="checkbox"/> satisfactory <input type="checkbox"/> fair <input type="checkbox"/> poor</p>
<p>31 How would you rate your overall quality of life during the last week?</p>	<p><input type="checkbox"/> excellent <input type="checkbox"/> good <input type="checkbox"/> satisfactory <input type="checkbox"/> fair <input type="checkbox"/> poor</p>
<p>32 How would you rate your overall quality of life compared with 10 years ago?</p>	<p><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</p>

G Mental Function

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

33 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
34 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
35 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
36 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
37 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
38 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
39 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

40 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
41 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