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# PARTICIPANT QUESTIONNAIRE (FU1)

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## 3 YEAR FOLLOW-UP

### ARMED SERVICES TRAUMA REHABILITATION OUTCOME STUDY

[ADVANCE STUDY]

[WWW.ADVANCESTUDYDMRC.ORG.UK](http://WWW.ADVANCESTUDYDMRC.ORG.UK)

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Date \_\_\_\_/\_\_\_\_/\_\_\_\_(dd/mm/yyyy)

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All information you provide is treated in the strictest confidence and stored securely in accordance with the Data Protection Act 2018 and UK General Data Protection Regulation 2018.

**PRIZE DRAW**

We appreciate you taking the time to participate in the ADVANCE Study and as a thank you, we are offering you the opportunity to take part in a prize draw either for yourself or for a charity of your choice each time you take part in the Study. We will be running the prize draw for the life of the Study and so when you visit us you will get the chance to win one of the following:

- 1<sup>st</sup> visit           **£1,000** (prizes = 1 x £500, 1 x £200, 3 x £100)
- 3 years:           **£2,000** (prizes = 1 x £750, 1 x £350, 2 x £200, 5 x £100)
- 5 years:           **£4,000** (prizes = 1 x £1,000, 1x £500, 2 x £250, 20 x £100)
- 10 years:          **£5,000** (prizes = 1 x £2,000, 1 x £1,000, 1 x £500, 15 x £100)
- 15 years:          **£7,000** (prizes = 1 x £2,500, 1x £1,500, 1 x £1,000, 20x £100)
- 20 years:          **£8,000** (prizes = 1 x £3,000, 1 x £1,500, 1 x 1,000, 25 x £100)

If you would like to be entered into the 2nd draw for the chance of winning between £100 and £750, please tick the box below.

☐

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## Section 1: Background Information

### 1.01 What is the highest level of education you have completed to date?

- |   |   |
|---|---|
| <input type="checkbox"/> 1 Left school with no qualifications               | <input type="checkbox"/> 4 Degree/NVQs level 4-5        |
| <input type="checkbox"/> 2 O levels/GCSEs/NVQs level 1-2 or equivalent      | <input type="checkbox"/> 5 Postgraduate qualifications  |
| <input type="checkbox"/> 3 A levels/HNDs/NVQs level 3/Highers or equivalent | <input type="checkbox"/> 6 Other (please specify) _____ |

### 1.02 The following questions are about you and your relationships.

What is your current relationship status? (select all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> 1 Married                     | <input type="checkbox"/> 5 Divorced                                   |
| <input type="checkbox"/> 2 Living with a partner       | <input type="checkbox"/> 6 Widowed                                    |
| <input type="checkbox"/> 3 In a long-term relationship | <input type="checkbox"/> 7 Single and not in a long-term relationship |
| <input type="checkbox"/> 4 Separated                   |   |

### 1.03 How satisfied are you with this relationship? (select one statement below)

- |   |   |
|---|---|
| <input type="checkbox"/> 1 Extremely satisfied                | <input type="checkbox"/> 4 Dissatisfied           |
| <input type="checkbox"/> 2 Satisfied                          | <input type="checkbox"/> 5 Extremely dissatisfied |
| <input type="checkbox"/> 3 Neither satisfied nor dissatisfied | <input type="checkbox"/> 6 Not Applicable         |

### 1.04 Who lives with you? (tick all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> 1 I live alone                         | <input type="checkbox"/> 4 Anyone else (please specify) _____       |
| <input type="checkbox"/> 2 Spouse/partner                       | <input type="checkbox"/> 5 Other relative(s) (please specify) _____ |
| <input type="checkbox"/> 3 Child(ren) over 18 (give ages) _____ |   |

Please tell us the age and gender of any children you have, and whether or not they live with you:

### 1.05. Do you have children?

(e.g. biological, adopted, step or foster)

- ☐1 Yes  
☐0 No (please proceed to Q1.06)

	Age	Male	Female	Lives with you	Does not live with you	Biological child	Adopted child	Stepchild	Foster child
Child 1		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
Child 2		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
Child 3		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
Child 4		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
Child 5		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
Child 6		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
Child 7		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8

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## Section 1: Background Information

### 1.06. Do you any brothers or sisters?

(e.g. biological, half or step)

☐<sub>1</sub> Yes (If Yes, how many?)

☐<sub>0</sub> No

	0	1	2	3	4	5	6	7	8
Sisters(s)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>
Brothers(s)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>
Half-sister(s)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>
Half-Brother(s)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>
Step sister(s)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>
Step brother(s)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>

### 1.07 Are you in contact with your parent(s)?

Mother	
Regular contact	<input type="checkbox"/> <sub>1</sub>
Some contact	<input type="checkbox"/> <sub>2</sub>
No contact	<input type="checkbox"/> <sub>3</sub>
Mother no longer alive	<input type="checkbox"/> <sub>4</sub>

Father	
Regular contact	<input type="checkbox"/> <sub>1</sub>
Some contact	<input type="checkbox"/> <sub>2</sub>
No contact	<input type="checkbox"/> <sub>3</sub>
Father no longer alive	<input type="checkbox"/> <sub>4</sub>

### 1.08 Does anyone help you with any of the following daily tasks? (select all applicable)

- ☐<sub>1</sub> Personal hygiene
- ☐<sub>2</sub> Using the bathroom
- ☐<sub>3</sub> Dressing
- ☐<sub>4</sub> Eating
- ☐<sub>5</sub> Mobility
- ☐<sub>6</sub> Basic communication skills
- ☐<sub>7</sub> Transportation

- ☐<sub>8</sub> Meal preparation
- ☐<sub>9</sub> Shopping
- ☐<sub>10</sub> Housework
- ☐<sub>11</sub> Managing medications
- ☐<sub>12</sub> Managing personal finances
- ☐<sub>13</sub> I do not need help with any of these daily tasks

### 1.09 If anyone helps you with daily tasks, who helps? (select all applicable)

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## Section 1: Background Information

- |   |  |
|---|--|
| <input type="checkbox"/> <sub>1</sub> Spouse/partner  | <input type="checkbox"/> <sub>5</sub> Brother or Sister                          |
| <input type="checkbox"/> <sub>2</sub> Mother  | <input type="checkbox"/> <sub>6</sub> Other family member (please specify) _____ |
| <input type="checkbox"/> <sub>3</sub> Father  | <input type="checkbox"/> <sub>7</sub> Other family member (please specify) _____ |
| <input type="checkbox"/> <sub>4</sub> Children (please state age of each in years)<br>_____ | <input type="checkbox"/> <sub>8</sub> Not applicable                             |

**1.10 We are interested in how you feel about the following statements.  
Read each statement carefully. Indicate how you feel about each statement.**

	Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
(1) There is a special person who is around when I am in need	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
(2) There is a special person with whom I can share my joys and sorrows	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
(3) My family really tries to help me	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
(4) I get the emotional help and support I need from my family	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
(5) I have a special person who is a real source of comfort to me	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
(6) My friends really try to help me	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
(7) I can count on my friends when things go wrong	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
(8) I can talk about my problems with my family	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
(9) I have friends with whom I can share my joys and sorrows	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
(10) There is a special person in my life who cares about my feelings	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
(11) My family is willing to help me make decisions	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>
(12) I can talk about my problems with my friends	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>

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## Section 1: Background Information

**1.11 People come to the military from a variety of different backgrounds. We are interested to see if and how experiences before you joined the Armed Forces affect your health and wellbeing.** Please read the following statements and tick TRUE or FALSE for each.

### When I was growing up...

	True	False
(1) I came from a close family	<input type="checkbox"/> 1	<input type="checkbox"/> 2
(2) I used to get shouted at a lot at home	<input type="checkbox"/> 1	<input type="checkbox"/> 2
(3) I often used to play truant from school	<input type="checkbox"/> 1	<input type="checkbox"/> 2
(4) I felt valued by my family	<input type="checkbox"/> 1	<input type="checkbox"/> 2
(5) I regularly used to see or hear physical fighting or verbal abuse between my parents	<input type="checkbox"/> 1	<input type="checkbox"/> 2
(6) In my family there was at least one member I could talk to about things that were important to me	<input type="checkbox"/> 1	<input type="checkbox"/> 2
(7) I used to get hit/hurt by a parent or caregiver regularly	<input type="checkbox"/> 1	<input type="checkbox"/> 2
(8) One (or more) of my parents had problems with alcohol or drugs	<input type="checkbox"/> 1	<input type="checkbox"/> 2
(9) My family used to do things together	<input type="checkbox"/> 1	<input type="checkbox"/> 2
(10) I often used to get into physical fights at school	<input type="checkbox"/> 1	<input type="checkbox"/> 2
(11) I was suspended/expelled from school (ever)	<input type="checkbox"/> 1	<input type="checkbox"/> 2
(12) I did things that should have got me (or did get me) in trouble with the police	<input type="checkbox"/> 1	<input type="checkbox"/> 2

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## Section 1: Background Information

**1.12 Some people report that their views and attitudes change FOR THE BETTER as a result of deployments. Below is a list of areas where you may have experienced change.** Please read each statement and tell us whether you have changed FOR THE BETTER as a result of ALL your deployments to Iraq/Afghanistan since 2002.

<b>As a result of my deployment(s) to Iraq or Afghanistan since 2002:</b>	<b>No change for the better</b>	<b>A small change for the better</b>	<b>Medium change for the better</b>	<b>A big change for the better</b>
(1) The things I see as being really important in my life have changed	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(2) I appreciate the value of my own life more	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(3) I developed new interests	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(4) I developed a greater feeling of self-reliance	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(5) I developed a better understanding of spiritual matters	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(6) I can see more clearly that I can count on people in times of trouble	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(7) I set up a new direction for my life	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(8) I feel closer to other people	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(9) I am more willing to express my emotions	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(10) I am more confident that I can handle difficulties	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(11) I am able to do better things with my life	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(12) I am better able to accept the way things work out	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(13) I can better appreciate each day	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(14) New opportunities are available which wouldn't have been otherwise	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(15) I am more understanding of others	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(16) I put more effort into my relationships	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(17) I am more likely to try to change things that need changing	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(18) I have a stronger religious faith	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(19) I discovered that I am stronger than I thought I was	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(20) I learned to appreciate other people	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(21) I am more able to accept that I need other people	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>



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## Section 2: FOR THOSE WHO HAVE LEFT THE ARMED FORCES

**2.0 If you are still serving in the Regular Armed Forces or in the Full Time Reserve Service, please tick this box and go to Section 3.**

☐<sub>1</sub> Yes

**2.1 Which of the following describe your reason for leaving the Armed Forces?** (please tick ALL that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> <sub>1</sub> Spouse/partner                               | <input type="checkbox"/> <sub>9</sub> Because of my experiences on deployment |
| <input type="checkbox"/> <sub>2</sub> Completed elective term of service           | <input type="checkbox"/> <sub>10</sub> Pressure from family                   |
| <input type="checkbox"/> <sub>3</sub> Better employment prospects in civilian life | <input type="checkbox"/> <sub>11</sub> Too many deployments                   |
| <input type="checkbox"/> <sub>4</sub> Impact of service life on family             | <input type="checkbox"/> <sub>12</sub> Didn't want to be away from home       |
| <input type="checkbox"/> <sub>5</sub> Work not exciting or challenging enough      | <input type="checkbox"/> <sub>13</sub> My service was terminated              |
| <input type="checkbox"/> <sub>6</sub> Dissatisfaction with pay                     | <input type="checkbox"/> <sub>14</sub> Health problems                        |
| <input type="checkbox"/> <sub>7</sub> Lack of promotion prospects                  | <input type="checkbox"/> <sub>15</sub> Accomplished everything I wanted       |
| <input type="checkbox"/> <sub>8</sub> Difficult to plan life outside of work       | <input type="checkbox"/> <sub>16</sub> Other (please specify) _____           |

**2.2 Are you currently employed?**

- ☐<sub>1</sub> Full-time
 ☐<sub>2</sub> Part-time
 ☐<sub>3</sub> No
 ☐<sub>4</sub> Other (Please describe) \_\_\_\_\_

**2.3 Are you currently in education or training?**

- ☐<sub>1</sub> Full-time
 ☐<sub>2</sub> Part-time
 ☐<sub>3</sub> No
 ☐<sub>4</sub> Other (Please describe) \_\_\_\_\_

**2.4 Have you been in trouble with the police/law since you left (NOT speeding/parking offences)?**

- ☐<sub>1</sub> Yes
 ☐<sub>0</sub> No

**2.5 How well would you say you are managing FINANCIALLY these days?** Would you say you are:

- |   |  |
|---|--|
| <input type="checkbox"/> <sub>1</sub> Living comfortably    | <input type="checkbox"/> <sub>4</sub> Finding it quite difficult |
| <input type="checkbox"/> <sub>2</sub> Doing alright         | <input type="checkbox"/> <sub>5</sub> Finding it very difficult  |
| <input type="checkbox"/> <sub>3</sub> Just about getting by |  |

**2.6 What is your longest period of unemployment since leaving the Armed Forces?** \_\_\_\_\_ months

**2.07(a) Please list all education or training courses you have attended since your last visit to the ADVANCE study.** (If exact date is unknown, please give closest date possible)

**Dates:** From [ / / ] To [ / / ]

**Institution:**

**Course title:**

**Dates:** From [ / / ] To [ / / ]

**Institution:**

**Course title:**

**Dates:** From [ / / ] To [ / / ]

**Institution:**

**Course title:**

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**Institution:**

**Course title:**

# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 2: FOR THOSE WHO HAVE LEFT THE ARMED FORCES

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<b>Institution:</b>
<b>Course title:</b>

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Institution:</b>
<b>Course title:</b>

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Institution:</b>
<b>Course title:</b>

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Institution:</b>
<b>Course title:</b>

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Institution:</b>
<b>Course title:</b>

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Institution:</b>
<b>Course title:</b>

**2.07(b) Please list all jobs you have attended since your last visit to the ADVANCE study.** (If exact date is unknown, please give closest date possible)

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Employer:</b>
<b>Job title:</b>
<b>Duties:</b>

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Employer:</b>
<b>Job title:</b>
<b>Duties:</b>

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## Section 2: FOR THOSE WHO HAVE LEFT THE ARMED FORCES

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Employer:</b>
<b>Job title:</b>
<b>Duties:</b>

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Employer:</b>
<b>Job title:</b>
<b>Duties:</b>

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Employer:</b>
<b>Job title:</b>
<b>Duties:</b>

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Employer:</b>
<b>Job title:</b>
<b>Duties:</b>

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Employer:</b>
<b>Job title:</b>
<b>Duties:</b>

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Employer:</b>
<b>Job title:</b>
<b>Duties:</b>

<b>Dates:</b> From [ / / ] To [ / / ]
<b>Employer:</b>
<b>Job title:</b>
<b>Duties:</b>

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## Section 3: Your Health and Lifestyle

### 3.01 Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?

Please tick the box that best describes your response.

	Not at all	Several days	More than half the days	Nearly every day
(1) Little interest or pleasure in doing things	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(2) Feeling down, depressed or hopeless	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(3) Trouble falling or staying asleep or sleeping too much	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(4) Feeling tired or having little energy	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(5) Poor appetite or overeating	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(6) Feeling bad about yourself – or that you are a failure, or have let yourself or your family down	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(7) Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(8) Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(9) Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

### 3.02 If you selected ANY problems listed above, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

- ☐<sub>1</sub> Not at all difficult  
☐<sub>2</sub> Somewhat difficult

- ☐<sub>3</sub> Very difficult  
☐<sub>4</sub> Extremely difficult

### 3.03 Over the LAST 2 WEEKS how often have you been bothered by the following problems?

Please select the answer that best describes your response.

	Not at all	Several days	More than half the days	Nearly every day
(1) Feeling nervous, anxious or on edge	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(2) Not being able to stop or control worrying	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(3) Worrying too much about different things	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(4) Trouble relaxing	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(5) Being so restless that it is hard to sit still	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(6) Becoming easily annoyed or irritable	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
(7) Feeling afraid as if something awful might happen	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

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## Section 3: Your Health and Lifestyle

**3.04 Under each heading, select ONE that best describes your health TODAY.**

### (1) Mobility

- |   |   |
|---|---|
| <input type="checkbox"/> <sub>1</sub> I have no problems in walking about       | <input type="checkbox"/> <sub>4</sub> I have severe problems in walking about |
| <input type="checkbox"/> <sub>2</sub> I have slight problems in walking about   | <input type="checkbox"/> <sub>5</sub> I am unable to walk about               |
| <input type="checkbox"/> <sub>3</sub> I have moderate problems in walking about |   |

### (2) Self-Care

- |   |   |
|---|---|
| <input type="checkbox"/> <sub>1</sub> I have no problems washing or dressing myself       | <input type="checkbox"/> <sub>4</sub> I have severe problems washing or dressing myself |
| <input type="checkbox"/> <sub>2</sub> I have slight problems washing or dressing myself   | <input type="checkbox"/> <sub>5</sub> I am unable to washing or dressing myself         |
| <input type="checkbox"/> <sub>3</sub> I have moderate problems washing or dressing myself |   |

### (3) Usual Activities (e.g. work, study, housework, family or leisure activities)

- |  |  |
|--|--|
| <input type="checkbox"/> <sub>1</sub> I have no problems doing my usual activities       | <input type="checkbox"/> <sub>4</sub> I have severe problems doing my usual activities |
| <input type="checkbox"/> <sub>2</sub> I have slight problems doing my usual activities   | <input type="checkbox"/> <sub>5</sub> I am unable to do my usual activities            |
| <input type="checkbox"/> <sub>3</sub> I have moderate problems doing my usual activities |  |

### (4) Pain/Discomfort

- |  |   |
|--|---|
| <input type="checkbox"/> <sub>1</sub> I have no pain or discomfort       | <input type="checkbox"/> <sub>4</sub> I have severe pain or discomfort  |
| <input type="checkbox"/> <sub>2</sub> I have slight pain or discomfort   | <input type="checkbox"/> <sub>5</sub> I have extreme pain or discomfort |
| <input type="checkbox"/> <sub>3</sub> I have moderate pain or discomfort |   |

### (5) Anxiety/Depression

- |  |   |
|--|---|
| <input type="checkbox"/> <sub>1</sub> I am not anxious or depressed        | <input type="checkbox"/> <sub>4</sub> I am severely anxious or depressed  |
| <input type="checkbox"/> <sub>2</sub> I am slightly anxious or depressed   | <input type="checkbox"/> <sub>5</sub> I am extremely anxious or depressed |
| <input type="checkbox"/> <sub>3</sub> I am moderately anxious or depressed |   |

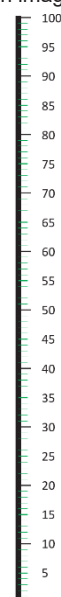
**3.05 We would like to know how good or bad your health is TODAY.**

- This scale is numbered from 0 to 100.
- 100 means the **BEST** health you can imagine.
- 0 means the **WORST** health you can imagine.
- Mark in **X** on the scale to indicate how your health is **TODAY**.
- Now please write the number you marked on the scale in the box below.

Your health today =

--

The best health  
you can imagine



The worst health  
you can imagine

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## Section 3: Your Health and Lifestyle

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **LAST 7 DAYS**. **Please answer each question even if you do not consider yourself to be an active person.** Please think about the activities you do at work, as part of your house and garden work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the **vigorous** and **moderate** activities that you did in the **LAST 7 DAYS**.

**Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal.

**Moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal.

### **PART 1: JOB-RELATED PHYSICAL ACTIVITY**

The first section is about your work. This includes paid jobs, farming, volunteer work, course work, and any other unpaid work that you did outside your home. **Do not** include unpaid work you might do around your home, like housework, gardening, general maintenance and caring for your family. These are asked about later in Part 3.

#### **3.06 Do you currently have a job or do any unpaid work outside your home?**

☐<sub>1</sub> Yes

☐<sub>2</sub> No

→ **SKIP TO PART 2: TRANSPORTATION (3.13)**

The next questions are about all the physical activity you did in the **last 7 days** as part of your paid or unpaid work. This does not include travelling to and from work.

#### **3.07 During the last 7 days on how many days did you do any VIGOROUS physical activities like heavy lifting, digging, heavy construction or climbing up stairs as part of your work? Think about only those physical activities that you did for at least 10 minutes at a time.**

☐<sub>1</sub> Yes, \_\_\_\_\_ days per week

☐<sub>2</sub> No vigorous job-related physical activity

→ **SKIP TO 3.09**

#### **3.08 How much time did you usually spend on one of those days doing vigorous physical activities as part of your work?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day

OR

☐<sub>2</sub> \_\_\_\_\_ Minutes per day

#### **3.09 Again, think about only those physical activities that you did for at least 10 minutes at a time. During the last 7 days on how many days did you do MODERATE physical activities like carrying light loads as part of your work? Please do not include walking.**

☐<sub>1</sub> Yes, \_\_\_\_\_ days per week

☐<sub>2</sub> No moderate job-related physical activity

→ **SKIP TO 3.11**

#### **3.10 How much time did you usually spend on one of those days doing moderate physical activities as part of your work?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day

OR

☐<sub>2</sub> \_\_\_\_\_ Minutes per day

#### **3.11 During the last 7 days, on how many days did you WALK for at least 10 minutes at a time as part of your work? Please do not count any walking you did to travel to or from work.**

☐<sub>1</sub> Yes, \_\_\_\_\_ days per week

☐<sub>2</sub> No moderate job-related physical activity

→ **SKIP TO 3.13**

#### **3.12 How much time did you usually spend on one of those days walking as part of your work?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day

OR

☐<sub>2</sub> \_\_\_\_\_ Minutes per day

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## Section 3: Your Health and Lifestyle

### PART 2: TRANSPORTATION PHYSICAL ACTIVITY

These questions are about how you travelled from place to place, including places like work, shops, cinema and so on.

**3.13 During the last 7 days, on how many days did you travel in a motor vehicle like a train, bus, car or tram?**

☐<sub>1</sub> Yes, \_\_\_\_\_ days per week

☐<sub>2</sub> No travelling in motor

→ SKIP TO 3.15

**3.14 How much time did you usually spend on one of those days travelling in a train, bus, car, tram or other kind of motor vehicle?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day

OR

☐<sub>2</sub> \_\_\_\_\_ Minutes per day

Now think only about the **cycling** and **walking** you might have done to travel to and from work, to do errands or to go from place to place.

**3.15 During the last 7 days on how many days did you cycle for at least 10 minutes at a time to go from place to place?**

☐<sub>1</sub> Yes, \_\_\_\_\_ days per week

☐<sub>2</sub> No cycling from place to place

→ SKIP TO 3.17

**3.16 How much time did you usually spend on one of those days cycling from place to place not for leisure?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day

OR

☐<sub>2</sub> \_\_\_\_\_ Minutes per day

**3.17 During the last 7 days on how many days did you walk for at least 10 minutes at a time to go to and from place to place not including walking for leisure?**

☐<sub>1</sub> Yes, \_\_\_\_\_ days per week

☐<sub>2</sub> No walking from place to place

→ SKIP TO PART 3: HOUSEWORK (3.19)

**3.18 How much time did you usually spend on one of those days walking from place to place?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day

OR

☐<sub>2</sub> \_\_\_\_\_ Minutes per day

### PART 3: HOUSEWORK, HOUSE MAINTENANCE AND CARING FOR FAMILY

This section is about some of the physical activities you might have done in the last 7 days in and around your home, like housework, gardening, general maintenance work and caring for your family. Think about only those physical activities that you did for at least 10 minutes at a time.

**3.19. During the last 7 days on how many days did you do vigorous physical activities like heavy lifting, chopping wood, shovelling snow or digging in the garden or yard?**

☐<sub>1</sub> Yes, \_\_\_\_\_ days per week

☐<sub>2</sub> No vigorous activity in garden

→ SKIP TO 3.21

**3.20 How much time did you usually spend on one of those days doing vigorous physical activities in the garden or yard?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day

OR

☐<sub>2</sub> \_\_\_\_\_ Minutes per day

**3.21 Again, think about only those physical activities that you did for at least 10 minutes at a time. During the last 7 days on how many days did you do moderate activities like carrying light loads, sweeping, washing windows and raking in the garden or yard?.**

☐<sub>1</sub> Yes, \_\_\_\_\_ days per week

☐<sub>2</sub> No moderate activity in garden

→ SKIP TO 3.23

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## Section 3: Your Health and Lifestyle

**3.22 How much time did you usually spend on one of those days doing moderate physical activities in the garden or yard?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day                      OR                      ☐<sub>2</sub> \_\_\_\_\_ Minutes per day

**3.23 Once again, think about only those physical activities that you did for at least 10 minutes at a time. During the last 7 days, on how many days did you do moderate activities like carrying light loads, washing windows, scrubbing floors and sweeping inside your home?**

☐<sub>1</sub> Yes, \_\_\_\_\_ days per week  
☐<sub>2</sub> No moderate activity inside home                      **→ SKIP TO PART 4: RECREATION (3.25)**

**3.24 How much time did you usually spend on one of those days doing moderate physical activities inside your home?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day                      OR                      ☐<sub>2</sub> \_\_\_\_\_ Minutes per day

### **PART 4: RECREATION, SPORT AND LEISURE-TIME PHYSICAL ACTIVITY**

This section is about all the physical activities that you did in the last 7 days solely for recreation, sport, exercise or leisure. Please do not include any activities you have already mentioned.

**3.25 Not counting any walking you have already mentioned, during the last 7 days, on how many days did you walk for at least 10 minutes at a time in your leisure time?**

☐<sub>1</sub> Yes, \_\_\_\_\_ days per week  
☐<sub>2</sub> No walking in leisure time                      **→ SKIP TO 3.27**

**3.26 How much time did you usually spend on one of those days walking in your leisure time?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day                      OR                      ☐<sub>2</sub> \_\_\_\_\_ Minutes per day

**3.27 Think about only those physical activities that you did for at least 10 minutes at a time. During the last 7 days on how many days did you do vigorous physical activities like aerobics, running, fast cycling or fast swimming in your leisure time?**

☐<sub>1</sub> Yes, \_\_\_\_\_ days per week  
☐<sub>2</sub> No vigorous activity in leisure time                      **→ SKIP TO 3.29**

**3.28 How much time did you usually spend on one of those days doing vigorous physical activities in your leisure time?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day                      OR                      ☐<sub>2</sub> \_\_\_\_\_ Minutes per day

**3.29 Again think only about those physical activities that you did for at least 10 minutes at a time. During the last 7 days on how many days did you do moderate physical activities like cycling at a regular pace, swimming at a regular pace and doubles tennis in your leisure time?**

☐<sub>1</sub> Yes, \_\_\_\_\_ days per week  
☐<sub>2</sub> No moderate activity in leisure time                      **→ SKIP TO PART 5: TIME SPENT SITTING (3.31)**

**3.30 How much time did you usually spend on one of those days doing moderate physical activities in your leisure time?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day                      OR                      ☐<sub>2</sub> \_\_\_\_\_ Minutes per day

### **PART 5: TIME SPENT SITTING**

The last questions are about the time you spend sitting while at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading or sitting or lying down to watch television. Do not include any time spent sitting in a motor vehicle that you have already told us about.

**3.31 During the last 7 days how much time did you usually spend sitting on a weekday?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day                      OR                      ☐<sub>2</sub> \_\_\_\_\_ Minutes per day

**3.32 During the last 7 days how much time did you usually spend sitting on a weekend day?**

☐<sub>1</sub> \_\_\_\_\_ Hours per day                      OR                      ☐<sub>2</sub> \_\_\_\_\_ Minutes per day



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**3.33 Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then tick one answer to indicate how much you have been bothered by that problem in the PAST MONTH.**

	Not at all	A little bit	Moderate	Quite a bit	Extremely
(1) Repeated, disturbing, and unwanted memories of the stressful experience?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(2) Repeated, disturbing dreams of the stressful experience?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(3) Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(4) Feeling very upset when something reminded you of the stressful experience?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(5) Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(6) Avoiding memories, thoughts, or feelings related to the stressful experience?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(7) Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(8) Trouble remembering important parts of the stressful experience?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(9) Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(10) Blaming yourself or someone else for the stressful experience or what happened after it?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(11) Having strong negative feelings such as fear, horror, anger, guilt, or shame?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(12) Loss of interest in activities that you used to enjoy?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(13) Feeling distant or cut off from other people?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(14) Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(15) Irritable behaviour, angry outbursts, or acting aggressively?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(16) Taking too many risks or doing things that could cause you harm?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(17) Being "superalert" or watchful or on guard?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(18) Feeling jumpy or easily startled?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(19) Having difficulty concentrating?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(20) Trouble falling or staying asleep?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(21) Feeling emotionally numb or being unable to have loving feelings to those who are close to you?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(22) Feeling as if your future will somehow be cut short?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 3: Your Health and Lifestyle

**3.34 Because alcohol can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol.**

Select one answer that best describes your answer to each question.

**(1) How often do you have a drink containing alcohol?**

- |   |  |
|---|--|
| <input type="checkbox"/> <sub>1</sub> Never             | <input type="checkbox"/> <sub>4</sub> 2-3 times a week       |
| <input type="checkbox"/> <sub>2</sub> Monthly or less   | <input type="checkbox"/> <sub>5</sub> 4 or more times a week |
| <input type="checkbox"/> <sub>3</sub> 2-4 times a month |  |

**(2) How many drinks containing alcohol do you have on a typical day when you are drinking?**

- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> <sub>1</sub> 1 or 2 | <input type="checkbox"/> <sub>2</sub> 3 or 4 | <input type="checkbox"/> <sub>3</sub> 5 or 6 | <input type="checkbox"/> <sub>4</sub> 7 to 9 | <input type="checkbox"/> <sub>5</sub> 10 or more |
|--|--|--|--|--|

**(3) How often do you have six or more drinks on one occasion?**

- |   |   |
|---|---|
| <input type="checkbox"/> <sub>1</sub> Never             | <input type="checkbox"/> <sub>4</sub> Weekly                |
| <input type="checkbox"/> <sub>2</sub> Less than monthly | <input type="checkbox"/> <sub>5</sub> Daily or almost daily |
| <input type="checkbox"/> <sub>3</sub> Monthly           |   |

**(4) How often during the last year have you found that you were not able to stop drinking once you had started?**

- |   |   |
|---|---|
| <input type="checkbox"/> <sub>1</sub> Never             | <input type="checkbox"/> <sub>4</sub> Weekly                |
| <input type="checkbox"/> <sub>2</sub> Less than monthly | <input type="checkbox"/> <sub>5</sub> Daily or almost daily |
| <input type="checkbox"/> <sub>3</sub> Monthly           |   |

**(5) How often during the last year have you failed to do what was normally expected of you because of drinking?**

- |   |   |
|---|---|
| <input type="checkbox"/> <sub>1</sub> Never             | <input type="checkbox"/> <sub>4</sub> Weekly                |
| <input type="checkbox"/> <sub>2</sub> Less than monthly | <input type="checkbox"/> <sub>5</sub> Daily or almost daily |
| <input type="checkbox"/> <sub>3</sub> Monthly           |   |

**(6) How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?**

- |   |   |
|---|---|
| <input type="checkbox"/> <sub>1</sub> Never             | <input type="checkbox"/> <sub>4</sub> Weekly                |
| <input type="checkbox"/> <sub>2</sub> Less than monthly | <input type="checkbox"/> <sub>5</sub> Daily or almost daily |
| <input type="checkbox"/> <sub>3</sub> Monthly           |   |

**(7) How often during the last year have you had a feeling of guilt or remorse after drinking?**

- |   |   |
|---|---|
| <input type="checkbox"/> <sub>1</sub> Never             | <input type="checkbox"/> <sub>4</sub> Weekly                |
| <input type="checkbox"/> <sub>2</sub> Less than monthly | <input type="checkbox"/> <sub>5</sub> Daily or almost daily |
| <input type="checkbox"/> <sub>3</sub> Monthly           |   |

**(8) How often during the last year have you been unable to remember what happened the night before because of your drinking?**

- |   |   |
|---|---|
| <input type="checkbox"/> <sub>1</sub> Never             | <input type="checkbox"/> <sub>4</sub> Weekly                |
| <input type="checkbox"/> <sub>2</sub> Less than monthly | <input type="checkbox"/> <sub>5</sub> Daily or almost daily |
| <input type="checkbox"/> <sub>3</sub> Monthly           |   |

**(9) Have you or someone else been injured because of your drinking?**

- |   |
|---|
| <input type="checkbox"/> <sub>1</sub> Never                         |
| <input type="checkbox"/> <sub>2</sub> Yes, but not in the last year |
| <input type="checkbox"/> <sub>3</sub> Yes, during the last year     |

**(10) Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?**

- |   |
|---|
| <input type="checkbox"/> <sub>1</sub> Never                         |
| <input type="checkbox"/> <sub>2</sub> Yes, but not in the last year |
| <input type="checkbox"/> <sub>3</sub> Yes, during the last year     |

# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 3: Your Health and Lifestyle

### LIST OF DRUGS

(Note! Not alcohol!)

Cannabis	Amphetamines	Cocaine	Opiates	Hallucinogens	Solvents/Inhalants	GHB and others
Marijuana	Methamphetamine	Crack	Smoked heroin	Ecstasy	Thinner	GHB
Hash	Phenmetraline	Freebase	Heroin	LSD (Lisergic acid)	Trichlorethylene	Anabolic steroids
Hash oil	Khat	Coca leaves	Opium	Mescaline	Gasoline/petrol	Laughing gas (Halothane)
	Betel nut			Peyote	Gas	Amyl nitrate (Poppers)
	Ritaline (Methylphenidate)			PCP, angel dust (Phencyclidine)	Solution	Anticholinergic compounds
				Psilocybin	Glue	
				DMT (Dimethyltryptamine)		

### PILLS – MEDICINES

Pills count as drugs when you take:

- More of them or take them more often than the doctor has prescribed for you.
- Pills because you want to have fun, feel good, get 'high' or wonder what sort of effect they have on you.
- Pills that you have received from a relative or a friend.
- Pills that you have bought on the 'black market' or stolen.

#### SLEEPING PILLS/SEDATIVES

Alprazolam	Glutethimide	Rohypnol
Amobarbital	Halcion	Secobarbital
Apodorm	Heminevrin	Sobril
Apozepam	Iktrivil	Sonata
Aprobarbital	Imovane	Stesolid
Butabarbital	Mephobarbital	Stilnoct
Butalbital	Meprobamate	Talbutal
Chloral hydrate	Methaqualone	Temesta
Diazepam	Methohexital	Thiamyl
Dormicum	Mogadon	Thiopental
Ethchlorvynol	Nitrazepam	Triazolam
Fenemal	Oxascand	Xanor
Flunitrazepam	Pentobarbital	Zopiklon
Fluscand	Phenobarbital	

#### PAINKILLERS

Actiq	Durogesic	OxyNorm
Coccilana-Etyfin	Fentanyl	Panocod
Citodon	Ketodur	Panocod forte
Citodon forte	Ketogan	Paraflex comp
Dexodon	Kodein	Somadril
Depolan	Maxidon	Spasmofen
Dexofen	Metadon	Subutex
Dilaudid	Morfin	Temgesic
Distalgesic	Nobligan	Tiparol
Dolcontin	Norflex	Tradolan
Doleron	Norgesic	Tramadol
Dolotard	Opidol	Treo comp
Doloxene	OxyContin	

**Pills do NOT count as drugs if they have been prescribed by a doctor and you take them in the prescribed dosage.**

**3.35 Here are a few questions about drugs. Please answer as correctly and honestly as possible by indicating which answer is right for you.**

**(1) How often do you use drugs other than alcohol? (See list of drugs above)**

- |   |   |
|---|---|
| <input type="checkbox"/> 1 Never                      | <input type="checkbox"/> 4 2-3 times a week             |
| <input type="checkbox"/> 2 Once a month or less often | <input type="checkbox"/> 5 4 times a week or more often |
| <input type="checkbox"/> 3 2-4 times a month          |   |

**(2) Do you use more than one type of drug on the same occasion?**

- |   |   |
|---|---|
| <input type="checkbox"/> 1 Never                      | <input type="checkbox"/> 4 2-3 times a week             |
| <input type="checkbox"/> 2 Once a month or less often | <input type="checkbox"/> 5 4 times a week or more often |
| <input type="checkbox"/> 3 2-4 times a month          |   |

# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 3: Your Health and Lifestyle

**(3) How many times do you take drugs on a typical day when you use drugs?**

- ☐<sub>1</sub> 0      ☐<sub>2</sub> 1-2      ☐<sub>3</sub> 3-4      ☐<sub>4</sub> 5-6      ☐<sub>5</sub> 7 or more

**(4) How often are you influenced heavily by drugs?**

- ☐<sub>1</sub> Never      ☐<sub>4</sub> 2-3 times a week  
☐<sub>2</sub> Once a month or less often      ☐<sub>5</sub> 4 times a week or more often  
☐<sub>3</sub> 2-4 times a month

**(5) Over the past year, have you felt that your longing for drugs was so strong that you could not resist it?**

- ☐<sub>1</sub> Never      ☐<sub>4</sub> 2-3 times a week  
☐<sub>2</sub> Once a month or less often      ☐<sub>5</sub> 4 times a week or more often  
☐<sub>3</sub> 2-4 times a month

**(6) Has it happened, over the past year, that you have not been able to stop taking drugs once you started?**

- ☐<sub>1</sub> Never      ☐<sub>4</sub> 2-3 times a week  
☐<sub>2</sub> Once a month or less often      ☐<sub>5</sub> 4 times a week or more often  
☐<sub>3</sub> 2-4 times a month

**(7) How often over the past year have you taken drugs and then neglected to do something you should have done?**

- ☐<sub>1</sub> Never      ☐<sub>4</sub> 2-3 times a week  
☐<sub>2</sub> Once a month or less often      ☐<sub>5</sub> 4 times a week or more often  
☐<sub>3</sub> 2-4 times a month

**(8) How often over the past year have you needed to take a drug the morning after heavy drug use the day before?**

- ☐<sub>1</sub> Never      ☐<sub>4</sub> 2-3 times a week  
☐<sub>2</sub> Once a month or less often      ☐<sub>5</sub> 4 times a week or more often  
☐<sub>3</sub> 2-4 times a month

**(9) How often over the past year have you had guilt feelings or a bad conscience because you used drugs?**

- ☐<sub>1</sub> Never      ☐<sub>4</sub> 2-3 times a week  
☐<sub>2</sub> Once a month or less often      ☐<sub>5</sub> 4 times a week or more often  
☐<sub>3</sub> 2-4 times a month

**(10) Have you or anyone else been hurt (mentally or physically) because you used drugs?**

- ☐<sub>1</sub> Never      ☐<sub>4</sub> 2-3 times a week  
☐<sub>2</sub> Once a month or less often      ☐<sub>5</sub> 4 times a week or more often  
☐<sub>3</sub> 2-4 times a month

**(11) Has a relative or a friend, a doctor or a nurse, or anyone else, been worried about your drug use or said to you that you should stop using drugs?**

- ☐<sub>1</sub> Never      ☐<sub>4</sub> 2-3 times a week  
☐<sub>2</sub> Once a month or less often      ☐<sub>5</sub> 4 times a week or more often  
☐<sub>3</sub> 2-4 times a month

# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 3: Your Health and Lifestyle

The following questions should be completed despite current frequency of sexual activity or practice method. Sexual activity includes two partner sexual activity as well as masturbation. You are encouraged to complete all questions, even if you are not sexually active or have no desire for sexual activity. Comments can be included at the end of the questions.

Under each heading, please tick **ONE** box that best describes your **OVERALL** level during the **PAST WEEK**, including **TODAY**

### 3.36 How strong is your sex drive?

- ☐<sub>1</sub> Extremely strong  
☐<sub>2</sub> Very strong  
☐<sub>3</sub> Somewhat strong

- ☐<sub>4</sub> Somewhat weak  
☐<sub>5</sub> No sex drive

### 3.37 How easily are you sexually aroused (turned on)?

- ☐<sub>1</sub> Extremely easily  
☐<sub>2</sub> Very easily  
☐<sub>3</sub> Somewhat easily

- ☐<sub>4</sub> Somewhat difficult  
☐<sub>5</sub> Never aroused

### 3.38 Can you easily get and keep an erection?

- ☐<sub>1</sub> Extremely easily  
☐<sub>2</sub> Very easily  
☐<sub>3</sub> Somewhat easily

- ☐<sub>4</sub> Somewhat difficult  
☐<sub>5</sub> Never

### 3.39 How easily can you reach orgasm?

- ☐<sub>1</sub> Extremely easily  
☐<sub>2</sub> Very easily  
☐<sub>3</sub> Somewhat easily

- ☐<sub>4</sub> Somewhat difficult  
☐<sub>5</sub> Never reached orgasm

### 3.40 Are your orgasms satisfying?

- ☐<sub>1</sub> Extremely satisfying  
☐<sub>2</sub> Very satisfying  
☐<sub>3</sub> Somewhat satisfying

- ☐<sub>4</sub> Somewhat unsatisfying  
☐<sub>5</sub> Can't reach orgasm

Comments:

## ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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### Section 3: Your Health and Lifestyle

**3.41** The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the PAST MONTH only. Please answer all questions

**a) During the past month, what time have you usually gone to bed at night?**

Usual bed time: \_\_\_\_\_ am/pm

**b) During the past month, how long (in minutes) has it usually taken you to fall asleep each night?**

\_\_\_\_\_ mins

**c) During the past month, what time have you usually got up in the morning?**

Usual getting up time: \_\_\_\_\_ am/pm

**d) During the past month, how many hours of actual sleep did you get per night**

**(this may be different from the number of hours you spend in bed)?** Hours of sleep per night: \_\_\_\_\_

**Have you had any of the following problems in the PAST MONTH?**

**e) Difficulty falling asleep**

☐<sub>1</sub> None      ☐<sub>2</sub> Mild      ☐<sub>3</sub> Moderate      ☐<sub>4</sub> Severe      ☐<sub>5</sub> Very Severe

**f) Difficulty staying asleep**

☐<sub>1</sub> None      ☐<sub>2</sub> Mild      ☐<sub>3</sub> Moderate      ☐<sub>4</sub> Severe      ☐<sub>5</sub> Very Severe

**Can you tell us how you rate your sleep?**

**g) How satisfied or dissatisfied are you with your current sleep pattern?**

☐<sub>1</sub> Very satisfied      ☐<sub>2</sub> Satisfied      ☐<sub>3</sub> Dissatisfied      ☐<sub>4</sub> Very dissatisfied

**h) If you have a sleep problem, does it INTERFERE with your daily functioning?**

(e.g. tiredness, work duties, memory etc.)

☐<sub>1</sub> Not at all interfering      ☐<sub>2</sub> A little bit      ☐<sub>3</sub> Somewhat      ☐<sub>4</sub> Quite a bit      ☐<sub>5</sub> Extremely

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## Section 4: Your Upper Body

Please answer these questions relating to **BACK PAIN**, even if you have no back pain at the moment.  
Please tick one statement.

### 4.01 Pain intensity

- |   |  |
|---|--|
| <input type="checkbox"/> <sub>1</sub> I have no pain at the moment        | <input type="checkbox"/> <sub>4</sub> The pain is fairly severe at the moment        |
| <input type="checkbox"/> <sub>2</sub> The pain is very mild at the moment | <input type="checkbox"/> <sub>5</sub> The pain is very severe at the moment          |
| <input type="checkbox"/> <sub>3</sub> The pain is moderate at the moment  | <input type="checkbox"/> <sub>6</sub> The pain is the worst imaginable at the moment |

### 4.02 Personal care (washing, dressing etc)

- |  |   |
|--|---|
| <input type="checkbox"/> <sub>1</sub> I can look after myself normally without causing extra pain  | <input type="checkbox"/> <sub>4</sub> I need some help but manage most of my personal care        |
| <input type="checkbox"/> <sub>2</sub> I can look after myself normally but it is very painful      | <input type="checkbox"/> <sub>5</sub> I need help every day in most aspects of self-care          |
| <input type="checkbox"/> <sub>3</sub> It is painful to look after myself and I am slow and careful | <input type="checkbox"/> <sub>6</sub> I do not get dressed, wash with difficulty, and stay in bed |

### 4.03 Lifting

- |  |   |
|--|---|
| <input type="checkbox"/> <sub>1</sub> I can lift heavy weights without extra pain  | <input type="checkbox"/> <sub>4</sub> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned |
| <input type="checkbox"/> <sub>2</sub> I can lift heavy weights but it gives extra pain   | <input type="checkbox"/> <sub>5</sub> I can lift only very light weights  |
| <input type="checkbox"/> <sub>3</sub> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table | <input type="checkbox"/> <sub>6</sub> I cannot lift or carry anything at all  |

### 4.04 Walking

- |  |  |
|--|--|
| <input type="checkbox"/> <sub>1</sub> Pain does not prevent me from walking any distance | <input type="checkbox"/> <sub>4</sub> Pain prevents me walking more than 100 yards/90 metres       |
| <input type="checkbox"/> <sub>2</sub> Pain prevents me walking more than 1 mile          | <input type="checkbox"/> <sub>5</sub> I can only walk using a stick or crutches                    |
| <input type="checkbox"/> <sub>3</sub> Pain prevents me walking more than ¼ of a mile     | <input type="checkbox"/> <sub>6</sub> I am in bed most of the time and have to crawl to the toilet |

### 4.05 Sitting

- |  |  |
|--|--|
| <input type="checkbox"/> <sub>1</sub> I can sit in any chair as long as I like           | <input type="checkbox"/> <sub>4</sub> Pain prevents me from sitting for more than 30 minutes |
| <input type="checkbox"/> <sub>2</sub> I can sit in my favourite chair as long as I like  | <input type="checkbox"/> <sub>5</sub> Pain prevents me from sitting for more than 10 minutes |
| <input type="checkbox"/> <sub>3</sub> Pain prevents me from sitting for more than 1 hour | <input type="checkbox"/> <sub>6</sub> Pain prevents me from sitting at all                   |

### 4.06 Standing

- |  |   |
|--|---|
| <input type="checkbox"/> <sub>1</sub> I can stand as long as I want without extra pain         | <input type="checkbox"/> <sub>4</sub> Pain prevents me from standing for more than 30 minutes |
| <input type="checkbox"/> <sub>2</sub> I can stand as long as I want but it gives me extra pain | <input type="checkbox"/> <sub>5</sub> Pain prevents me from standing for more than 10 minutes |
| <input type="checkbox"/> <sub>3</sub> Pain prevents me from standing more than 1 hour          | <input type="checkbox"/> <sub>6</sub> Pain prevents me from standing at all                   |

### 4.07 Sleeping

- |  |  |
|--|--|
| <input type="checkbox"/> <sub>1</sub> My sleep is never disturbed by pain            | <input type="checkbox"/> <sub>4</sub> Because of pain I have less than 4 hours sleep |
| <input type="checkbox"/> <sub>2</sub> My sleep is occasionally disturbed by pain     | <input type="checkbox"/> <sub>5</sub> Because of pain I have less than 2 hours sleep |
| <input type="checkbox"/> <sub>3</sub> Because of pain I have less than 6 hours sleep | <input type="checkbox"/> <sub>6</sub> Pain prevents me from sleeping at all          |

### 4.08 Sex life (if applicable)

- |  |  |
|--|--|
| <input type="checkbox"/> <sub>1</sub> My sex life is normal and causes no extra pain   | <input type="checkbox"/> <sub>4</sub> My sex life is severely restricted by pain   |
| <input type="checkbox"/> <sub>2</sub> My sex life is normal but causes some extra pain | <input type="checkbox"/> <sub>5</sub> My sex life is nearly absent because of pain |
| <input type="checkbox"/> <sub>3</sub> My sex life is nearly normal but is very painful | <input type="checkbox"/> <sub>6</sub> Pain prevents any sex life at all            |

## ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 4: Your Upper Body

## 4.09 Social life

- ☐<sub>1</sub> My social life is normal and causes me no extra pain
- ☐<sub>2</sub> My social life is normal but increases the degree of pain
- ☐<sub>3</sub> Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sports
- ☐<sub>4</sub> Pain has restricted my social life and I do not go out as often
- ☐<sub>5</sub> Pain has restricted my social life to my home
- ☐<sub>6</sub> I have no social life because of pain

## 4.10 Travelling

- ☐1 I can travel anywhere without pain
- ☐2 I can travel anywhere but it gives me extra pain
- ☐3 Pain is bad but I manage journeys of just over two hours
- ☐4 Pain restricts me to journeys of less than 1 hour
- ☐5 Pain has restricted my social life to my home
- ☐6 I have no social life because of pain

**4.11 Over the past three months have you received treatment, tablets or medicines of any kind for your BACK or LEG PAIN?**

- ☐<sub>1</sub> No  
☐<sub>2</sub> Yes (please describe treatment below)

**The following questions are about your lower back. For each question, please circle the appropriate box.**

**4.12 How would you score the SEVERITY of your lower back pain on average over the LAST WEEK?**

Circle the appropriate box.

Worst pain  
imaginable

**For each of the following questions, please circle the appropriate box.**

**4.13 How would you score the FREQUENCY of your lower back pain on average over the LAST WEEK?**

Constant

**4.14 How would you score the IMPACT of your lower back pain on your day-to-day activities on average over the LAST WEEK?**

Highest impact  
imaginable



# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 4: Your Upper Body

**4.15** These questions ask about symptoms as well as your ability to perform certain activities in the last week. If you did not have the opportunity to perform an activity in the last week, please make your best estimate on which response would be the most accurate. It doesn't matter which hand or arm you use. Please answer based on your ability regardless of how you perform the task. Please rate your ability to do the following in the **LAST WEEK**:

	Not difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Unable
(1) Open a tight or new jar	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(2) Write	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(3) Turn a key	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(4) Prepare a meal	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(5) Push open a heavy door	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(6) Place an object on a shelf above your head	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(7) Do heavy household jobs (e.g. wash walls, wash floors)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(8) Garden or do yard work	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(9) Make a bed	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(10) Carry a shopping bag or briefcase	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(11) Carry a heavy object (over 10lbs/4.5kgs)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(12) Change a light bulb overhead	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(13) Wash or blow dry your hair	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(14) Wash your back	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(15) Put on a pullover/sweater	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(16) Use a knife to cut food	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(17) Recreational activities which require little effort (eg. card playing)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(18) Recreational activities in which you take some force or impact through your arm, shoulder or hand (eg. golf, hammering, tennis etc.)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(19) Recreational activities in which you move your arm freely (eg. playing frisbee, badminton etc.)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(20) Manage transportation needs (getting from one place to another)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(21) Sexual activities	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

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## Section 4: Your Upper Body

(22) During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?

- ☐ 1 Not at all  
☐ 2 Slightly  
☐ 3 Moderately  
☐ 4 Quite a bit  
☐ 5 Extremely

(23) During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?

- ☐ 1 Not limited at all  
☐ 2 Slightly limited  
☐ 3 Moderately limited  
☐ 4 Very limited  
☐ 5 Unable

Please rate the severity of the following symptoms in the LAST WEEK

	None	Mild	Moderate	Severe	Extreme
(24) Arm, shoulder or hand pain	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(25) Arm, shoulder or hand pain when you performed any specific activity	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(26) Tingling (pins and needles) in your arm, shoulder or hand	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(27) Weakness in your arm, shoulder or hand	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(28) Stiffness in your arm, shoulder or hand	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(29) During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(30) I feel less capable, less confident or less useful because of my arm, shoulder or hand problem	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including home-making, if that is your main work role).

4.16 Please indicate what your main work/job is:

\_\_\_\_\_

If you do not work, tick here and go to 4.17. ☐ 1

During the PAST WEEK did you have any difficulty: (tick the response)

	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Unable
(1) Using your usual technique for your work?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(2) Doing your usual work because of arm, shoulder or hand pain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(3) Doing your work as well as you would like?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(4) Spending your usual amount of time doing your work?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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## Section 4: Your Upper Body

The following questions relate to the impact of your arm, shoulder or hand problem on playing your musical instrument, or sport, or both. If you play more than one sport or instrument (or play both) please answer with respect to the activity that is most important to you.

**4.17 Please indicate the sport or instrument which is most important to you:**

\_\_\_\_\_

If you do not play a sport or instrument, tick here and skip to Section 5. ☐1

**During the PAST WEEK did you have any difficulty: (tick the response)**

	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Unable
(1) Using your usual technique for playing your instrument or sport?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(2) Playing your musical instrument or sport because of arm, shoulder or hand pain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(3) Playing your musical instrument or sport as well as you would like?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
(4) Spending your usual amount of time practising or playing your instrument or sport?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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## Section 5: Your Lower Body

The following questions ask for your view about your knee(s).

Tick box if you have had both legs amputated above the knee and go to question 5.43 HIP PAIN ☐1

Answer every question by ticking the appropriate box, but only **ONE** box for each question. If these questions apply to **BOTH** knees, tick **ONE** box for each question for each knee. If you do not have knee pain, please still answer these questions.

If you are unsure about how to answer the question, please give the best answer you can.

### SYMPTOMS

These questions should be answered by thinking of your knee symptoms during the **LAST WEEK**

[If applicable, leave amputated side blank]

	Never	Rarely	Sometimes	Often	Always
<b>5.01 Do you have swelling in your knee?</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.02 Do you feel grinding, hear clicking or any other type of noise when your knee moves?</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.03 Does your knee catch or hang up when moving?</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.04 Can you straighten your knee fully?</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.05 Can you bend your knee fully?</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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## Section 5: Your Lower Body

### STIFFNESS

The following questions concern the amount of joint stiffness you have experienced during the **LAST WEEK** in your knee(s). Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint(s).

If you do not have stiffness in your knee(s) or knee pain, please still answer these questions. If you are unsure about how to answer the question, please give the best answer you can. Select the appropriate box.

	None	Mild	Moderate	Severe	Extreme
<b>5.06 How severe is your knee joint stiffness after FIRST WAKING IN THE MORNING?</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.07 How severe is your knee stiffness after sitting, lying or resting LATER IN THE DAY?</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

### PAIN

	None	Monthly	Weekly	Daily	Always
[If applicable, leave amputated side blank].					
<b>5.08 How often do you experience knee pain?</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

If you have answered 'NEVER' to q 5.8 for BOTH knees please go to Daily Living q 5.17.

If your answer to 5.8 is either 'Monthly, Weekly, Daily or Always' for one or both knees, please answer the following questions.

What amount of knee pain have you experienced in the LAST WEEK during the following activities?

	None	Mild	Moderate	Severe	Extreme
<b>5.09 Twisting/pivoting on your knee</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.10 Straightening your knee fully</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.11 Bending your knee fully</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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## Section 5: Your Lower Body

	None	Mild	Moderate	Severe	Extreme
<b>5.12 Walking on a flat surface</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.13 Going up or down stairs</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.14 At night whilst in bed</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.15 Sitting or lying</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.16 Standing upright</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

## FUNCTIONAL, DAILY LIVING

The following questions about your physical function. By this we mean your ability to move around and look after yourself. For each of the following activities please indicate how much difficulty you have experienced in the **LAST WEEK** due to your knee(s).

If you are unsure about how to answer the question, please give the best answer you can.

Tick the appropriate box.

	None	Mild	Moderate	Severe	Extreme
<b>5.17 Going down stairs</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.18 Going up stairs</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.19 Rising from sitting</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.20 Standing</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.21 Bending to floor/pick up an object</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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## Section 5: Your Lower Body

	None	Mild	Moderate	Severe	Extreme
<b>5.22 Walking on a flat surface</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.23 Getting in/out of the car</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.24 Going shopping</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.25 Putting on socks</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.26 Rising from bed</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.27 Taking off socks</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.28 Lying in bed (turning over, maintaining knee position)</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.29 Getting in/out of bath</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.30 Sitting</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.31 Getting on/off of toilet</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.32 Heavy domestic duties (moving heavy boxes, scrubbing floors etc.)</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.33 Light domestic duties (cooking, dusting etc.)</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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## Section 5: Your Lower Body

### FUNCTION, SPORT AND RECREATIONAL ACTIVITIES

The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the LAST WEEK due to your knee(s). Tick the appropriate box.

#### PHYSICAL ACTIVITIES

	None	Mild	Moderate	Severe	Extreme
<b>5.34 Squatting</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.35 Running</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.36 Jumping</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.37 Twisting/pivoting on your knee</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.38 Kneeling</b>					
Left Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Knee	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

#### QUALITY OF LIFE

<b>5.39 How often are you aware of your knee problem?</b>					
Left Knee	<input type="checkbox"/> 1 Never	<input type="checkbox"/> 2 Monthly	<input type="checkbox"/> 3 Weekly	<input type="checkbox"/> 4 Daily	<input type="checkbox"/> 5 Constantly
Right Knee	<input type="checkbox"/> 1 Never	<input type="checkbox"/> 2 Monthly	<input type="checkbox"/> 3 Weekly	<input type="checkbox"/> 4 Daily	<input type="checkbox"/> 5 Constantly
<b>5.40 Have you modified your life-style to avoid potentially damaging activities to your knee?</b>					
Left Knee	<input type="checkbox"/> 1 Not at all	<input type="checkbox"/> 2 Mildly	<input type="checkbox"/> 3 Moderately	<input type="checkbox"/> 4 Severely	<input type="checkbox"/> 5 Totally
Right Knee	<input type="checkbox"/> 1 Not at all	<input type="checkbox"/> 2 Mildly	<input type="checkbox"/> 3 Moderately	<input type="checkbox"/> 4 Severely	<input type="checkbox"/> 5 Totally
<b>5.41 How much are you troubled with lack of confidence in your knee?</b>					
Left Knee	<input type="checkbox"/> 1 Not at all	<input type="checkbox"/> 2 Mildly	<input type="checkbox"/> 3 Moderately	<input type="checkbox"/> 4 Severely	<input type="checkbox"/> 5 Totally
Right Knee	<input type="checkbox"/> 1 Not at all	<input type="checkbox"/> 2 Mildly	<input type="checkbox"/> 3 Moderately	<input type="checkbox"/> 4 Severely	<input type="checkbox"/> 5 Totally
<b>5.42 In general, how much difficulty do you have with your knee?</b>					
Left Knee	<input type="checkbox"/> 1 None	<input type="checkbox"/> 2 Mild	<input type="checkbox"/> 3 Moderate	<input type="checkbox"/> 4 Severe	<input type="checkbox"/> 5 Extreme
Right Knee	<input type="checkbox"/> 1 None	<input type="checkbox"/> 2 Mild	<input type="checkbox"/> 3 Moderate	<input type="checkbox"/> 4 Severe	<input type="checkbox"/> 5 Extreme



# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 5: Your Lower Body

### HIP PAIN

The following questions concern the amount of pain you are currently experiencing in the hip(s). Please tick the response that most accurately reflects the amount of hip pain experienced in the PAST 48 HOURS.

How much pain do you have with:	None	Mild	Moderate	Severe	Extreme
<b>5.43 Walking on a flat surface?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.44 Going up or down stairs?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.45 At night while in bed?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.46 Sitting or lying?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.47 Standing upright?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

The following FOUR questions concern the SYMPTOMS you are currently experiencing in your hip(s). For each situation, please tick the appropriate box that most accurately reflects the amount of pain experienced in the PAST 48 HOURS.

How much trouble do you have with:	None	Mild	Moderate	Severe	Extreme
<b>5.48 Catching or locking of your hip?</b>					
Left hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.49 Your hip giving way on you?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.50 Stiffness in your hip?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.51 Decreased movement in your hip?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

The following FIVE questions concern your PHYSICAL FUNCTION. For each of the following activities please tick the appropriate box that most accurately reflects the difficulty you have experienced in the PAST 48 HOURS because of your hip pain.

# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 5: Your Lower Body

What degree of difficulty do you have with:

	None	Mild	Moderate	Severe	Extreme
<b>5.52 Going down stairs?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.53 Going up stairs?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.54 Rising from sitting?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.55 Putting on socks?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.56 Rising from bed?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

The following SIX questions concern your ability to participate in certain types of activities. For each of the following activities please tick the appropriate box that most accurately reflects the difficulty you have experienced in the LAST MONTH because of your hip pain.

If you do not participate in a certain type of activity, please estimate how much trouble your hip would have caused if you had to perform that type of activity.

How much pain do you have in:

	None	Mild	Moderate	Severe	Extreme
<b>5.57 High demand sports involving sprinting or cutting (e.g. football, basketball, tennis and aerobics)?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.58 Low-demand sports (e.g. golf/bowling)?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.59 Jogging for exercise?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.60 Walking for exercise?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.61 Heavy household duties (e.g. lifting firewood/moving furniture)?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>5.62 Light household duties (e.g. cooking, dusting, vacuuming and laundry)?</b>					
Left Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right Hip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 5: Your Lower Body

Circle the appropriate box. If you have had no knee or hip joint pain in the LAST WEEK, tick here and skip to q 5.75. ☐1

5.63 How would you score the SEVERITY of pain in your LEFT KNEE on average over the LAST WEEK?

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pain  
imaginable

5.64 How would you score the FREQUENCY of pain in your LEFT KNEE on average over the LAST WEEK?

None

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Constant

5.65 How would you score the IMPACT of your LEFT KNEE pain on your day-to-day activities on average over the LAST WEEK?

No impact

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Highest impact  
imaginable

5.66 How would you score the SEVERITY of pain in your RIGHT KNEE on average over the LAST WEEK?

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pain  
imaginable

5.67 How would you score the FREQUENCY of pain in your RIGHT KNEE on average over the LAST WEEK?

None

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Constant

5.68 How would you score the IMPACT of your RIGHT KNEE pain on your day-to-day activities on average over the LAST WEEK?

No impact

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Highest impact  
imaginable

5.69 How would you score the SEVERITY of pain in your LEFT HIP on average over the LAST WEEK?

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pain  
imaginable

5.70 How would you score the FREQUENCY of pain in your LEFT HIP on average over the LAST WEEK?

None

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Constant

5.71 How would you score the IMPACT of your LEFT HIP pain on your day-to-day activities on average over the LAST WEEK?

No impact

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Highest impact  
imaginable

5.72 How would you score the SEVERITY of pain in your RIGHT HIP on average over the LAST WEEK?

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pain  
imaginable

5.73 How would you score the FREQUENCY of pain in your RIGHT HIP on average over the LAST WEEK?

None

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Constant

5.74 How would you score the IMPACT of your RIGHT HIP pain on your day-to-day activities on average over the LAST WEEK?

No impact

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Highest impact  
imaginable

# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## 5.75 During the PAST 4 WEEKS this has applied to me:

(please tick one box for each statement)		None of the time	Rarely	Some of the time	Most of the time	All of the time
<b>[a] I have pain in my foot/ankle</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[b] I avoid walking long distances because of pain in my foot/ankle</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[c] I change the way I walk due to pain in my foot/ankle</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[d] I walk slowly because of pain in my foot/ankle</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[e] I have to stop and rest my foot/ankle because of pain</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[f] I avoid some hard or rough surfaces because of pain in my foot/ankle</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[g] I avoid standing for a long time because of pain in my foot/ankle</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[h] I catch the bus or use the car instead of walking, because of pain in my foot/ankle</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[i] I feel self-conscious about my foot/ankle</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[j] I feel self-conscious about the shoes I have to wear</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[k] The pain in my foot/ankle is more painful in the evening</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[l] I get shooting pains in my foot/ankle</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[m] The pain in my foot/ankle prevents me from carrying out my work/everyday activities</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<b>[n] I am unable to do all my social or recreational activities because of pain in my foot/ankle</b>						
Left		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Right		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

## ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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### Section 5: Your Lower Body

**5.76 During the PAST 4 WEEKS how would you describe the pain you usually have in your foot/ankle?**  
(please tick one box)

☐ 1 None

☐ 2 Very mild

☐ 3 Mild

☐ 4 Moderate

☐ 5 Severe

**5.77 During the PAST 4 WEEKS have you been troubled by pain from your foot/ankle in bed at night?**  
(please tick one box)

☐ 1 No nights

☐ 2 Only 1 or 2 nights

☐ 3 Some nights

☐ 4 More nights

☐ 5 Every night

# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 6: Your Overall Well-being

**6.1** Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery. We are interested in the types of thoughts and feeling that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain.

Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
(1) I worry all the time about whether the pain will end	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(2) I feel I can't go on	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(3) It's terrible and I think it's never going to get any better	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(4) It's awful and I feel that it overwhelms me	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(5) I feel I can't stand it anymore	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(6) I become afraid that the pain will get worse	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(7) I keep thinking of other painful events	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(8) I anxiously want the pain to go away	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(9) I can't seem to keep it out of my mind	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(10) I keep thinking about how much it hurts	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(11) I keep thinking about how badly I want the pain to stop	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(12) There's nothing I can do to reduce the intensity of the pain	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
(13) I wonder whether something serious may happen	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**6.02** Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain TODAY?

☐<sub>1</sub> Yes

☐<sub>2</sub> No  
(go to 6.08)

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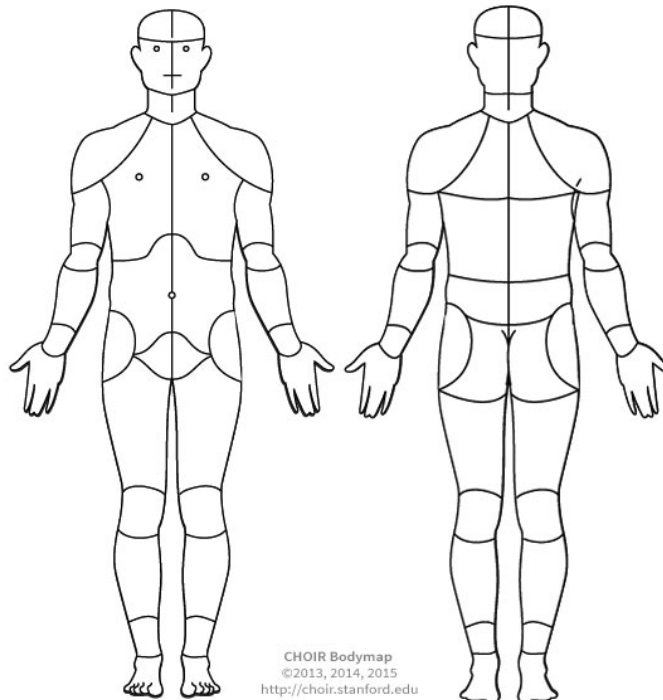
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## Section 6: Your Overall Well-being

6.03 (a) On the diagrams, shade all the areas where you feel pain.

The image on the  
LEFT side is the  
FRONT of the body.

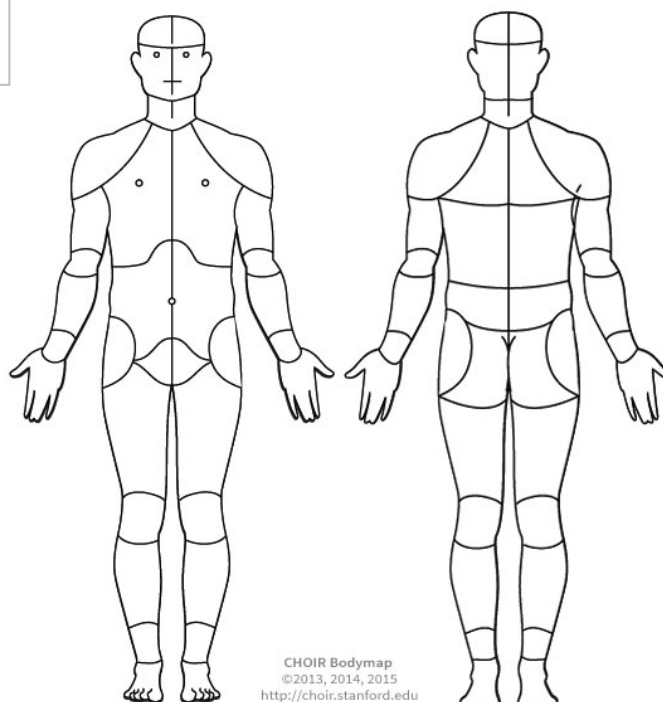


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RIGHT side is the  
BACK of the body.

CHOIR Bodymap  
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6.03 (b) On the diagrams, please mark (using X) the SINGLE AREA that hurts the most.

The image on the  
LEFT side is the  
FRONT of the body.



The image on the  
RIGHT side is the  
BACK of the body.

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# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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4 letter code

## Section 6: Your Overall Well-being

**6.04 Please rate your pain by selecting the number that best describes your pain at its WORST in the LAST 24 HOURS.**

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst Pain as bad as you can imagine

**6.05 Select the number that best describes your pain at its LEAST in the LAST 24 HOURS.**

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst Pain as bad as you can imagine

**6.06 Select the number that best describes your pain on the AVERAGE.**

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst Pain as bad as you can imagine

**6.07 Select the number that tells how much pain you have RIGHT NOW.**

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst Pain as bad as you can imagine

**6.08 Are you receiving any treatments or medications for your pain?**

☐<sub>1</sub> Yes (Please describe below) ☐<sub>2</sub> No

**What treatments or medications are you receiving for your pain?**

**6.09 In the LAST 24 HOURS, how much relief have pain treatments or medications provided?**

Please select the percentage that most shows how much relief you have received..

No relief

10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
-----	-----	-----	-----	-----	-----	-----	-----	-----	------

Complete relief

**Select the number that describes how, during the PAST 24 HOURS, pain has interfered with the following daily activities:**

	Does not interfere	1	2	3	4	5	6	7	8	9	Completely interferes
<b>6.10 General Activity</b>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>	<input type="checkbox"/> <sub>9</sub>	<input type="checkbox"/> <sub>10</sub>
<b>6.11 Mood</b>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>	<input type="checkbox"/> <sub>9</sub>	<input type="checkbox"/> <sub>10</sub>
<b>6.12 Walking Ability</b>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>	<input type="checkbox"/> <sub>9</sub>	<input type="checkbox"/> <sub>10</sub>
<b>6.13 Normal Work</b> (includes both work outside the home and housework)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>	<input type="checkbox"/> <sub>9</sub>	<input type="checkbox"/> <sub>10</sub>
<b>6.14 Relations with other people</b>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>	<input type="checkbox"/> <sub>9</sub>	<input type="checkbox"/> <sub>10</sub>
<b>6.15 Sleep</b>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>	<input type="checkbox"/> <sub>9</sub>	<input type="checkbox"/> <sub>10</sub>
<b>6.16 Enjoyment of life</b>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>	<input type="checkbox"/> <sub>8</sub>	<input type="checkbox"/> <sub>10</sub>



# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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4 letter code

## Section 6: Your Overall Well-being

We wish to know if you feel spontaneous pain, that is pain without any stimulation. For each of the following questions, please select the number that best describes the average severity of your spontaneous pain during the PAST 24 HOURS. Select the number 0 if you have not felt such pain.

6.17 Does your pain feel like burning?

No burning

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst burning  
imaginable

6.18 Does your pain feel like squeezing?

No squeezing

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst squeezing  
imaginable

6.19 Does your pain feel like pressure?

No pressure

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pressure  
imaginable

6.20 During the PAST 24 HOURS, how long has your spontaneous pain been present:

Select the box that best describes your case.

- ☐ 1 Permanently
 ☐ 2 Between 8 and 12 hrs
 ☐ 3 Between 4 and 7 hrs
 ☐ 4 Between 1 and 3 hrs
 ☐ 5 Less than 1hour

We wish to know if you have brief attacks of pain. For each of the following questions, please select the number that best describes the average severity of your painful attacks during the PAST 24 HOURS.

Select the number 0 if you have not felt such pain.

6.21 Does your pain feel like electric shocks?

No electric shocks

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst electric  
shock imaginable

6.22 Does your pain feel like stabbing?

No stabbing

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst stabbing  
imaginable

6.23 During the PAST 24 HOURS, how many of these pain attacks have you had?

Tick the response that best describes your case.

- ☐ 1 More than 20
 ☐ 2 Between 11 and 20
 ☐ 3 Between 6 and 10
 ☐ 4 Between 1 and 5
 ☐ 5 No pain attack

We wish to know if your pain is provoked or increased by brushing, pressure, contact with something cold on the painful area. For each of the following questions, please select the number that best describes the average severity of your provoked pain during the PAST 24 HOURS.

Select the number 0 if you have not felt such pain.

6.24 Is your pain provoked or increased by brushing on the painful area?

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pain  
imaginable

6.25 Is your pain provoked or increased by pressure on the painful area?

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pain  
imaginable

6.26 Is your pain provoked or increased by contact with something cold on the painful area

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst Pain as bad  
as you can imagine

# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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4 letter code

## Section 6: Your Overall Well-being

**We wish to know if you feel abnormal sensations in the painful area.** For each of the following questions, please select the number that best describes the average severity of your abnormal sensations during the PAST 24 HOURS.

### 6.27 Do you feel pins and needles?

No pins & needles

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pins & needles  
imaginable

### 6.28 Do you feel tingling?

No tingling

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst tingling  
imaginable

### 6.29 Does the pain have one or more of the following characteristics?

	Yes	No
(a) Burning	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
(b) Painful cold	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
(c) Electric shocks	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
6.30 Is the pain associated with one or more of the following symptoms in the same area?		
(a) Tingling	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
(b) Pins & Needles	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
(c) Numbness	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
(d) Itching	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 7: For Amputees Only

7.01 Please select Yes or No after each question, as it is most true for you.

	Yes	No
a) Do you wear prosthetic leg(s)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
b) Do you wear your prosthetic leg(s) for cosmetic appearance only? (ie. you do not walk on it/them).	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
c) Do you wear your prosthetic leg(s) to help you move very short distances? (e.g. move from bed to chair or chair to toilet).	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
d) Are you receiving any nursing care at present? If Yes please read on, if No skip to question (f).	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
e) Do you wear your prosthetic leg(s) to help you with any nursing care you may be receiving?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
f) Are you receiving any physiotherapy/occupational therapy at present? If Yes please read on, if No skip to question (h).	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
g) Do you wear any prosthetic leg(s) to help you with any therapy you may be receiving?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
h) Do you usually walk indoors, wearing your prosthetic leg(s)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
i) Do you usually need the physical help of another person to help you walk indoors, when you wear your prosthetic leg(s)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
j) Indoors, wearing your prosthetic leg(s), do you usually need the help of a walking frame?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
k) Indoors, wearing your prosthetic leg(s), do you usually need the help of 2 crutches to walk?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
l) Indoors, wearing your prosthetic leg(s), do you usually need the help of 2 sticks to walk?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
m) Indoors, wearing your prosthetic leg(s), do you usually need the help of 1 crutch / stick to walk?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
n) Indoors, do you usually use any walking aid at all?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
o) Can you usually manage to walk more than 50m (55 yards) at a time?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
p) Do you usually walk outdoors, wearing your prosthetic leg(s)?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
q) Do you usually only walk on level ground?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
r) Outdoors, do you usually need the help of a walking frame to walk?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
s) Outdoors, do you usually need the help of 2 crutches to walk?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
t) Outdoors, do you usually need the help of 2 sticks to walk?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
u) Outdoors, do you usually need the help of 1 crutch/stick to walk?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
v) Outdoors, do you <b>OCCASIONALLY</b> use a walking aid to increase your confidence in adverse weather conditions or on uneven ground?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
w) Outdoors, wearing your prosthetic leg(s), do you walk anywhere, in any weather conditions, <b>WITHOUT</b> using <b>ANY WALKING AID</b> at all?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 7: For Amputees Only

**7.02 The following questions relate to your amputated and prosthetic limb(s)**

Please answer all the questions for each limb(s) separately.

### LIMB 1

Which amputated limb are you referring to? \_\_\_\_\_

What is the level of amputation? \_\_\_\_\_  
(eg. above/through/below knee/elbow/ankle etc)

For each of the following questions for LIMB 1 mark X in the appropriate box.

**7.03 How would you score the COMFORT of the socket fit in your artificial limb?**

Most uncomfortable  
socket fit Imaginable

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Most comfortable  
socket fit Imaginable

**7.04 How would you score your overall SATISFACTION of your artificial limb?**

Most unsatisfied  
socket fit Imaginable

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Most satisfied  
socket fit Imaginable

**7.05 How many days in the LAST WEEK have you used your prosthetic?**

0	1	2	3	4	5	6	7
---	---	---	---	---	---	---	---

**7.06 On average how many hours per day have you used your prosthetic?** \_\_\_\_\_ hours per day

**7.07 How would you score the SEVERITY of your phantom pain in your amputated limb on average over the LAST WEEK?**

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pain  
imaginable

**7.08 How would you score the overall FREQUENCY of phantom pain in your amputated limb on average over the LAST WEEK?**

None

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Constant

**7.09 How would you score the IMPACT of phantom pain in your amputated limb on your day-to-day activities on average over the LAST WEEK?**

No impact

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Highest impact  
imaginable

**7.10 How would you score the SEVERITY of stump pain in your amputated limb on average over the LAST WEEK?**

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pain  
imaginable

**7.11 How would you score the FREQUENCY of stump pain in your amputated limb on average over the LAST WEEK?**

None

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Constant

**7.12 How would you score the IMPACT of stump pain in your amputated limb on your day-to-day activities on average over the LAST WEEK?**

No impact

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Highest impact  
imaginable

Tick here if you have only one amputated limb and skip the rest of the questions in this section.

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# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 7: For Amputees Only

### LIMB 2

7.13 Which amputated limb are you referring to? \_\_\_\_\_

7.14 What is the level of amputation? \_\_\_\_\_  
(eg. above/through/below knee/elbow/ankle etc)

For each of the following questions for LIMB 2 mark X in the appropriate box.

7.15 How would you score the COMFORT of the socket fit in your artificial limb?

Most uncomfortable  
socket fit Imaginable

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Most comfortable  
socket fit Imaginable

7.16 How would you score your overall SATISFACTION of your artificial limb?

Most unsatisfied  
socket fit Imaginable

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Most satisfied  
socket fit Imaginable

7.17 How many days in the LAST WEEK have you used your prosthetic?

0	1	2	3	4	5	6	7
---	---	---	---	---	---	---	---

7.18 On average how many hours per day have you used your prosthetic? \_\_\_\_\_ hours per day

7.19 How would you score the SEVERITY of your phantom pain in your amputated limb on average over the LAST WEEK?

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pain  
imaginable

7.20 How would you score the overall FREQUENCY of phantom pain in your amputated limb on average over the LAST WEEK?

None

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Constant

7.21 How would you score the IMPACT of phantom pain in your amputated limb on your day-to-day activities on average over the LAST WEEK?

No impact

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Highest impact  
imaginable

7.22 How would you score the SEVERITY of stump pain in your amputated limb on average over the LAST WEEK?

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pain  
imaginable

7.23 How would you score the FREQUENCY of stump pain in your amputated limb on average over the LAST WEEK?

None

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Constant

7.24 How would you score the IMPACT of stump pain in your amputated limb on your day-to-day activities on average over the LAST WEEK?

No impact

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Highest impact  
imaginable

Tick here if you have only two amputated limbs and skip the rest of the questions in this section.

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# ADVANCE STUDY – PARTICIPANT QUESTIONNAIRE

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## Section 7: For Amputees Only

### LIMB 3

7.25 Which amputated limb are you referring to? \_\_\_\_\_

7.26 What is the level of amputation? \_\_\_\_\_  
(eg. above/through/below knee/elbow/ankle etc)

For each of the following questions for LIMB 2 mark X in the appropriate box.

7.27 How would you score the COMFORT of the socket fit in your artificial limb?

Most uncomfortable  
socket fit Imaginable

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Most comfortable  
socket fit Imaginable

7.28 How would you score your overall SATISFACTION of your artificial limb?

Most unsatisfied  
socket fit Imaginable

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Most satisfied  
socket fit Imaginable

7.29 How many days in the LAST WEEK have you used your prosthetic?

0	1	2	3	4	5	6	7
---	---	---	---	---	---	---	---

7.30 On average how many hours per day have you used your prosthetic? \_\_\_\_\_ hours per day

7.31 How would you score the SEVERITY of your phantom pain in your amputated limb on average over the LAST WEEK?

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pain  
imaginable

7.32 How would you score the overall FREQUENCY of phantom pain in your amputated limb on average over the LAST WEEK?

None

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Constant

7.33 How would you score the IMPACT of phantom pain in your amputated limb on your day-to-day activities on average over the LAST WEEK?

No impact

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Highest impact  
imaginable

7.34 How would you score the SEVERITY of stump pain in your amputated limb on average over the LAST WEEK?

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Worst pain  
imaginable

7.35 How would you score the FREQUENCY of stump pain in your amputated limb on average over the LAST WEEK?

None

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Constant

7.36 How would you score the IMPACT of stump pain in your amputated limb on your day-to-day activities on average over the LAST WEEK?

No impact

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Highest impact  
imaginable