



ARMED
SERVICES
TRAUMA
REHABILITATION
OUTCOME
STUDY

Participant Study Number: **A D V** /

Date: ____ / ____ / ____ (dd/mm/yyyy)

Participant Study Number:

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*“All of the information you give us in the questionnaire is stored securely. No-one outside the research team will be able to identify you from the answers you give in this questionnaire. The only time we might share your personal identifiers (your name, date of birth, NHS number) would be in order to link these to other datasets (for example, with your medical records if you have consented for us to do so). We will **NOT** pass any of your contact details (address, email address or phone number) to third parties.”*

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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 every five years you will get the chance to win one of the following:

- 1st visit: **£1,000** (prizes = 1 x £500, 1 x £200, 3 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 1st draw for the chance of winning between £100 and £500, please tick the box below.

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All your answers to the questions in this questionnaire are treated with the utmost confidentiality. We would like you to answer all questions as honestly as you can.

SECTION A: SIGAM (MOBILITY) QUESTIONNAIRE

Please tick Yes or No after each question, as it is most true for you

	Yes	No
Q1. Do you wear prosthetic leg(s)	<input type="checkbox"/>	<input type="checkbox"/>
Q2. Do you wear your prosthetic leg(s) for cosmetic appearance only? (ie. you do not walk on them)	<input type="checkbox"/>	<input type="checkbox"/>
Q3. Do you wear your prosthetic leg(s) to help you move very short distances? (ie. move from bed to chair or chair to toilet)	<input type="checkbox"/>	<input type="checkbox"/>
Q4. Are you receiving any nursing care at present? If Yes please read on, <u>if No skip to Q6.</u>	<input type="checkbox"/>	<input type="checkbox"/>
Q5. Do you wear your prosthetic leg(s) to help you with any nursing care you may be receiving?	<input type="checkbox"/>	<input type="checkbox"/>
Q6. Are you receiving any physiotherapy/occupational therapy at present? If Yes please read on, <u>if No skip to Q8.</u>	<input type="checkbox"/>	<input type="checkbox"/>
Q7. Do you wear any prosthetic leg(s) to help you with any therapy you may be receiving?	<input type="checkbox"/>	<input type="checkbox"/>
Q8. Do you usually walk indoors at all, wearing your prosthetic leg(s)?	<input type="checkbox"/>	<input type="checkbox"/>
Q9. Do you usually need the physical help of another person to help you walk indoors, if you wear your prosthetic leg(s)?	<input type="checkbox"/>	<input type="checkbox"/>
Q10. Indoors, wearing your prosthetic leg(s) do you usually need the help of a walking frame?	<input type="checkbox"/>	<input type="checkbox"/>
Q11. Indoors, wearing your prosthetic leg(s), do you usually need the help of 2 crutches to walk?	<input type="checkbox"/>	<input type="checkbox"/>
Q12. Indoors, wearing your prosthetic leg(s), do you usually need the help of 2 sticks to walk?	<input type="checkbox"/>	<input type="checkbox"/>

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	Yes	No
Q13. Indoors, wearing your prosthetic leg(s), do you usually need the help of 1 crutch/stick to walk?	<input type="checkbox"/>	<input type="checkbox"/>
Q14. Indoors, do you usually use any walking aid at all?	<input type="checkbox"/>	<input type="checkbox"/>
Q15. Do you usually manage to walk more than 50m (55 yards) at a time?	<input type="checkbox"/>	<input type="checkbox"/>
Q16. Do you usually walk outdoors at all, wearing your prosthetic leg(s)?	<input type="checkbox"/>	<input type="checkbox"/>
Q17. Do you usually walk on level ground only?	<input type="checkbox"/>	<input type="checkbox"/>
Q18. Outdoors, do you usually need the help of a walking frame to walk?	<input type="checkbox"/>	<input type="checkbox"/>
Q19. Outdoors, do you usually need the help of 2 crutches to walk?	<input type="checkbox"/>	<input type="checkbox"/>
Q20. Outdoors, do you usually need the help of 2 sticks to walk?	<input type="checkbox"/>	<input type="checkbox"/>
Q21. Outdoors, do you usually need the help of 1 crutch/stick to walk?	<input type="checkbox"/>	<input type="checkbox"/>
Q22. Outdoors, do you OCCASIONALLY use a walking aid to increase your confidence in adverse weather conditions or on uneven ground?	<input type="checkbox"/>	<input type="checkbox"/>
Q23. Outdoors, wearing your prosthetic leg(s), do you walk anywhere, in any weather conditions, without using any walking aid at all?	<input type="checkbox"/>	<input type="checkbox"/>

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SECTION B: AMPUTATED/PROSTHETIC LIMB(S) QUESTIONNAIRE

The following questions relate to your amputated and prosthetic limb(s). Please answer all the questions for each limb(s) separately. If you are unsure about how to answer any of these questions, please DO ask one of the ADVANCE Study team who will be happy to help you.

LIMB 1

Q24. Which amputated limb are you referring to? _____

Q25. What is the level of amputation? _____
(eg. above/through/below – elbow/knee/ankle)

*For each of the following questions for **LIMB 1**, please mark an X in the appropriate box.*

SOCKET COMFORT SCORE:

Q26. How would you score the **COMFORT** of the socket fit in your artificial limb?

Most
uncomfortable
socket fit
imaginable

Most
comfortable
socket fit
imaginable

PROSTHETIC SATISFACTION SCORE

Q27. How would you score your overall **SATISFACTION** of your artificial limb?

Most
unsatisfied
socket fit
imaginable

Most
satisfied
socket fit
imaginable

PROSTHETIC USE

Q28. How much have you used your prosthesis in the **LAST WEEK**? _____ (days)

Q29. On average how many **hours per day** have you used your prosthesis? _____ (hours)

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PHANTOM PAIN SCORE

Q30. How would you score the **SEVERITY** of your phantom pain in your amputated limb on average over the **LAST WEEK**?

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

No pain

Worst pain
imaginable

Q31. How would you score the overall **FREQUENCY** of phantom pain in your amputated limb on average over the **LAST WEEK**?

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

None

Constant

Q32. 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**?

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

No impact

Highest
impact
imaginable

STUMP PAIN SCORE

Q33. How would you score the **SEVERITY** of stump pain in your amputated limb on average over the **LAST WEEK**?

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

No pain

Worst pain
imaginable

Q34. How would you score the **FREQUENCY** of stump pain in your amputated limb on average over the **LAST WEEK**?

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

None

Constant

Q35. 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**?

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

No impact

Highest
impact
imaginable

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*If you have only one amputated limb and have answered Questions 24-35, please **GO TO Q60***

If you have two or more amputated limbs, please answer the following questions.

LIMB 2

Q36. Which amputated limb are you referring to? _____

Q37. What is the level of amputation? _____
(eg. above/through/below – elbow/knee/ankle)

*For each of the following questions for **LIMB 2**, please mark an X in the appropriate box.*

SOCKET COMFORT SCORE:

Q38. How would you score the **COMFORT** of the socket fit in your artificial limb?

0	1	2	3	4	5	6	7	8	9	10	
Most uncomfortable socket fit imaginable											Most comfortable socket fit imaginable

PROSTHETIC SATISFACTION SCORE

Q39. How would you score your overall **SATISFACTION** of your artificial limb?

0	1	2	3	4	5	6	7	8	9	10	
Most unsatisfied socket fit imaginable											Most satisfied socket fit imaginable

PROSTHETIC USE

Q40. How much have you used your prosthesis in the **LAST WEEK**? _____ (days)

Q41. On average how many **hours per day** have you used your prosthesis? _____ (hours)

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PHANTOM PAIN SCORE

Q42. How would you score the **SEVERITY** of your phantom pain in your amputated limb on average over the **LAST WEEK**?

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

No pain

Worst pain
imaginable

Q43. How would you score the overall **FREQUENCY** of phantom pain in your amputated limb on average over the **LAST WEEK**?

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

None

Constant

Q44. 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**?

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

No impact

Highest
impact
imaginable

STUMP PAIN SCORE

Q45. How would you score the **SEVERITY** of stump pain in your amputated limb on average over the **LAST WEEK**?

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

No pain

Worst pain
imaginable

Q46. How would you score the **FREQUENCY** of stump pain in your amputated limb on average over the **LAST WEEK**?

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

None

Constant

Q47. 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**?

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

No impact

Highest
impact
imaginable

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*If you have only two amputated limbs and have answered Questions 24-37, please **GO TO Q60***

LIMB 3

Q48. Which amputated limb are you referring to? _____

Q49. What is the level of amputation? _____
(eg. above/through/below – elbow/knee/ankle)

*For each of the following questions for **LIMB 3**, please mark an X in the appropriate box.*

SOCKET COMFORT SCORE:

Q50. How would you score the **COMFORT** of the socket fit in your artificial limb?

<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>	<input type="text" value="7"/>	<input type="text" value="8"/>	<input type="text" value="9"/>	<input type="text" value="10"/>	
Most uncomfortable socket fit imaginable											Most comfortable socket fit imaginable

PROSTHETIC SATISFACTION SCORE

Q51. How would you score your overall **SATISFACTION** of your artificial limb?

<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>	<input type="text" value="7"/>	<input type="text" value="8"/>	<input type="text" value="9"/>	<input type="text" value="10"/>	
Most unsatisfied socket fit imaginable											Most satisfied socket fit imaginable

PROSTHETIC USE

Q52. How much have you used your prosthesis in the **LAST WEEK**? _____ (days)

Q53. On average how many **hours per day** have you used your prosthesis? _____ (hours)

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PHANTOM PAIN SCORE

Q54. How would you score the **SEVERITY** of your phantom pain in your amputated limb on average over the **LAST WEEK**?

No pain

Worst pain
imaginable

Q55. How would you score the overall **FREQUENCY** of phantom pain in your amputated limb on average over the **LAST WEEK**?

None

Constant

Q56. 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

Highest
impact
imaginable

STUMP PAIN SCORE

Q57. How would you score the **SEVERITY** of stump pain in your amputated limb on average over the **LAST WEEK**?

No pain

Worst pain
imaginable

Q58. How would you score the **FREQUENCY** of stump pain in your amputated limb on average over the **LAST WEEK**?

None

Constant

Q59. 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

Highest
impact
imaginable

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SECTION C: BACK PAIN SCORE

For each of the following questions, please **Mark X** in the appropriate box

Q60. How would you score the **SEVERITY** of your lower back pain on average over the **LAST WEEK**?

Mark an **X** in the appropriate box.

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

No pain

Worst pain
imaginable

Q61. How would you score the **FREQUENCY** of your lower back pain on average over the **LAST WEEK**?

Mark an **X** in the appropriate box.

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

None

Constant

Q62. How would you score the **IMPACT** of your lower back pain on your day-to-day activities on average in the **LAST WEEK**? Mark an **X** in the appropriate box.

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

No impact

Highest
impact
imaginable

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SECTION D: OSWESTRY DISABILITY INDEX

*Please answer these questions relating to **BACK PAIN**, even if you have no back pain at the moment.
Mark an **X** in the appropriate box for each question heading.*

Q63. Pain intensity

- | | |
|--|--------------------------|
| (a) I have no pain at the moment | <input type="checkbox"/> |
| (b) The pain is very mild at the moment | <input type="checkbox"/> |
| (c) The pain is moderate at the moment | <input type="checkbox"/> |
| (d) The pain is fairly severe at the moment | <input type="checkbox"/> |
| (e) The pain is very severe at the moment | <input type="checkbox"/> |
| (f) The pain is the worst imaginable at the moment | <input type="checkbox"/> |

Q64. Personal care (washing, dressing, etc.)

- | | |
|--|--------------------------|
| (a) I can look after myself normally without causing extra pain | <input type="checkbox"/> |
| (b) I can look after myself normally but it is very painful | <input type="checkbox"/> |
| (c) It is painful to look after myself and I am slow and careful | <input type="checkbox"/> |
| (d) I need some help but manage most of my personal care | <input type="checkbox"/> |
| (e) I need help every day in most aspects of self-care | <input type="checkbox"/> |
| (f) I do not get dressed, wash with difficulty, and stay in bed | <input type="checkbox"/> |

Q65. Lifting

- | | |
|--|--------------------------|
| (a) I can lift heavy weights without extra pain | <input type="checkbox"/> |
| (b) I can lift heavy weights but it gives extra pain | <input type="checkbox"/> |
| (c) Pain prevents me from lifting heavy weights off of the floor,
but I can manage if they are conveniently positioned
e.g. on a table | <input type="checkbox"/> |
| (d) Pain prevents me from lifting heavy weights, but I can
manage light to medium weights if they are conveniently
positioned | <input type="checkbox"/> |
| (e) I can lift very light weights | <input type="checkbox"/> |
| (f) I cannot lift or carry anything at all | <input type="checkbox"/> |

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Q66. Walking

- (a) Pain does not prevent me from walking any distance ☐
- (b) Pain prevents me walking more than 1 mile ☐
- (c) Pain prevents me walking more than ¼ of a mile ☐
- (d) Pain prevents me walking more than 100 yards/90 metres ☐
- (e) I can only walk using a stick or crutches ☐
- (f) I am in bed most of the time and have to crawl to the toilet ☐

Q67. Sitting

- (a) I can sit in any chair as long as I like ☐
- (b) I can sit in my favourite chair as long as I like ☐
- (c) Pain prevents me from sitting for more than 1 hour ☐
- (d) Pain prevents me from sitting for more than 30 minutes ☐
- (e) Pain prevents me from sitting for more than 10 minutes ☐
- (f) Pain prevents me from sitting at all ☐

Q68. Standing

- (a) I can stand as long as I want without extra pain ☐
- (b) I can stand as long as I want but it gives me extra pain ☐
- (c) Pain prevents me from standing more than 1 hour ☐
- (d) Pain prevents me from standing for more than 30 minutes ☐
- (e) Pain prevents me from standing for more than 10 minutes ☐
- (f) Pain prevents me from standing at all ☐

Q69. Sleeping

- (a) My sleep is never disturbed by pain ☐
- (b) My sleep is occasionally disturbed by pain ☐
- (c) Because of pain I have less than 6 hours sleep ☐
- (d) Because of pain I have less than 4 hours sleep ☐
- (e) Because of pain I have less than 2 hours sleep ☐
- (f) Pain prevents me from sleeping at all ☐

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Q70. Sex life (if applicable)

- (a) My sex life is normal and causes no extra pain ☐
- (b) My sex life is normal but causes some extra pain ☐
- (c) My sex life is nearly normal but is very painful ☐
- (d) My sex life is severely restricted by pain ☐
- (e) My sex life is nearly absent because of pain ☐
- (f) Pain prevents any sex life at all ☐

Q71. Social life

- (a) My social life is normal and causes me no extra pain ☐
- (b) My social life is normal but increases the degree of pain ☐
- (c) Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sports ☐
- (d) Pain has restricted my social life and I do not go out as often ☐
- (e) Pain has restricted my social life to my home ☐
- (f) I have no social life because of pain ☐

Q72. Travelling

- (a) I can travel anywhere without pain ☐
- (b) I can travel anywhere but it gives me extra pain ☐
- (c) Pain is bad but I manage journeys just over two hours ☐
- (d) Pain restricts me to journeys of less than 1 hour ☐
- (e) Pain restricts me to short, necessary journeys under 30 minutes ☐
- (f) Pain prevents me from travelling except to receive treatment ☐

Q73. Previous treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your **BACK** or **LEG PAIN**? (Mark an X in the appropriate box).

Yes ☐ (if Yes, please state type of treatment you have received)

No ☐

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SECTION E: KNEE INJURY AND OSTEOARTHRITIS OUTCOME SCORE (KOOS)

The following questions ask for your view about your knee(s). Some military veterans may experience conditions that affect their bones, muscles or joints, particularly in the knees or hips. It is important for us to be aware of any symptoms you might have presently. This information will help us keep track of how you feel about your knee(s) and how well you are able to perform usual activities.

☐ Tick box if you have had **both** legs amputated above the knee and go to **SECTION F (p.23)**.

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**.

Q74. Do you have swelling in your knee?

Left knee:	Never	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Often	<input type="checkbox"/>	Always	<input type="checkbox"/>
Right knee:	Never	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Often	<input type="checkbox"/>	Always	<input type="checkbox"/>

Q75. Do you feel grinding, hear clicking or any other type of noise when your knee moves?

Left knee:	Never	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Often	<input type="checkbox"/>	Always	<input type="checkbox"/>
Right knee:	Never	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Often	<input type="checkbox"/>	Always	<input type="checkbox"/>

Q76. Does your knee catch or hang up when moving?

Left knee:	Never	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Often	<input type="checkbox"/>	Always	<input type="checkbox"/>
Right knee:	Never	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Often	<input type="checkbox"/>	Always	<input type="checkbox"/>

Q77. Can you straighten your knee fully?

Left knee:	Never	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Often	<input type="checkbox"/>	Always	<input type="checkbox"/>
Right knee:	Never	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Often	<input type="checkbox"/>	Always	<input type="checkbox"/>

Q78. Can you bend your knee fully?

Left knee:	Never	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Often	<input type="checkbox"/>	Always	<input type="checkbox"/>
Right knee:	Never	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Often	<input type="checkbox"/>	Always	<input type="checkbox"/>

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STIFFNESS

The following questions concern the amount of joint stiffness and pain 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(s) pain, please still answer these questions. If you are unsure about how to answer the question, please give the best answer you can. *Mark X in the appropriate box.*

Q79. How severe is your knee joint stiffness after FIRST WAKING IN THE MORNING?

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Q80. How severe is your knee stiffness after sitting, lying or resting LATER IN THE DAY?

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

PAIN

Q81. How often do you experience knee pain?

Left knee: Never ☐ Monthly ☐ Weekly ☐ Daily ☐ Always ☐

Right knee: Never ☐ Monthly ☐ Weekly ☐ Daily ☐ Always ☐

If you have answered 'NEVER' to Q81 for BOTH knees please go to Section F (p.23). If your answer to Q81. is either 'Monthly, Weekly, Daily or Always' for one or both knees, please answer the following questions.

Q82. What amount of knee pain have you experienced in the LAST WEEK during the following activities?

(a) Twisting/pivoting on your knee

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(b) Straightening your knee fully

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

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(c) Bending your knee fully

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(d) Walking on a flat surface

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(e) Going up or down stairs

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(f) At night whilst in bed

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(g) Sitting or lying

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(h) Standing upright

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

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FUNCTION, DAILY LIVING

The following questions concern your physical function. By this we mean your ability to move around and look after yourself.

Q83. For each of the following activities please indicate the degree of 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. Mark **X** in the appropriate box.*

(a) Descending stairs

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(b) Ascending stairs

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(c) Rising from sitting

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(d) Standing

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(e) Bending to floor/pick up an object

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(f) Walking on a flat surface

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

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For each of the following activities please indicate the degree of difficulty you have experienced in the **LAST WEEK** due to your knee(s).

(g) Getting in/out of car

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(h) Going shopping

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(i) Putting on socks

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(j) Rising from bed

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(k) Taking off socks

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(l) Lying in bed (turning over, maintaining knee position)

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(m) Getting in/out of bath

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(n) Sitting

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

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For each of the following activities please indicate the degree of difficulty you have experienced in the **LAST WEEK** due to your knee(s).

(o) Getting on/off of toilet

Left knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

(p) Heavy domestic duties (moving heavy boxes, scrubbing floors etc.)

Left knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

(q) Light domestic duties (cooking, dusting etc.)

Left knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

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FUNCTION, SPORT AND RECREATIONAL ACTIVITIES

Q84. 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). *Mark X in the appropriate box.*

PHYSICAL ACTIVITIES

(a) Squatting

Left knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

(b) Running

Left knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

(c) Jumping

Left knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

(d) Twisting/pivoting on your knee

Left knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

(e) Kneeling

Left knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right knee:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

QUALITY OF LIFE

Q85. How often are you aware of your knee problem?

Left knee:	Never	<input type="checkbox"/>	Monthly	<input type="checkbox"/>	Weekly	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Constantly	<input type="checkbox"/>
Right knee:	Never	<input type="checkbox"/>	Monthly	<input type="checkbox"/>	Weekly	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Constantly	<input type="checkbox"/>

Q86. Have you modified your life-style to avoid potentially damaging activities to your knee?

Left knee:	Not at all	<input type="checkbox"/>	Mildly	<input type="checkbox"/>	Moderately	<input type="checkbox"/>	Severely	<input type="checkbox"/>	Totally	<input type="checkbox"/>
Right knee:	Not at all	<input type="checkbox"/>	Mildly	<input type="checkbox"/>	Moderately	<input type="checkbox"/>	Severely	<input type="checkbox"/>	Totally	<input type="checkbox"/>

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Q87. How much are you troubled with lack of confidence in your knee?

Left knee: Not at all ☐ Mildly ☐ Moderately ☐ Severely ☐ Totally ☐
Right knee: Not at all ☐ Mildly ☐ Moderately ☐ Severely ☐ Totally ☐

Q88. In general, how much difficulty do you have with your knee?

Left knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐
Right knee: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

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SECTION F: NON ARTHRITIC HIP SCORE (NAHS)

The following **FIVE** questions concern the amount of pain you are currently experiencing in the hip(s).

For each situation, please mark **X** in the appropriate box that most accurately reflects the amount of pain experienced in the **LAST 48 HOURS**.

Q89. How much pain do you have:

(a) Walking on a flat surface?

Left hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

(b) Going up and down stairs?

Left hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

(c) At night while in bed?

Left hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

(d) Sitting or lying?

Left hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

(e) Standing upright?

Left hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

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

Q90. How much trouble do you have with:

(a) Catching or locking of your hip?

Left hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(b) Your hip giving way on you?

Left hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(c) Stiffness in your hip?

Left hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(d) Decreased movement in your hip?

Left hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

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

Q91. What degree of difficulty do you have with:

(a) Descending stairs?

Left hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(b) Ascending stairs?

Left hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

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(c) Rising from sitting?

Left hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(d) Putting on socks?

Left hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(e) Rising from bed?

Left hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

*The following **SIX** questions concern your ability to participate in certain types of activities. For each of the following activities please mark **X** in **the appropriate** box that 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.

Q92. How much pain do you have in:

(a) High demand sports involving sprinting or cutting (e.g. football, basketball, tennis and aerobics)?

Left hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(b) Low-demand sports (e.g. golf/bowling)?

Left hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

(c) Jogging for exercise?

Left hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Right hip: None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

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(d) Walking for exercise?

Left hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

(e) Heavy household duties (e.g. lifting firewood/moving furniture)?

Left hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

(f) Light household duties (e.g. cooking, dusting, vacuuming and laundry)?

Left hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>
Right hip:	None	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	Extreme	<input type="checkbox"/>

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SECTION G: KNEE AND HIP JOINT PAIN

Please mark an **X** in one appropriate box for each question. If you have had no knee or hip joint pain in the **LAST WEEK**, please mark an **X** in the following box and skip to **Section H (p. 29)**. ☐

Q93. LEFT KNEE

(a) How would you score the **SEVERITY** of pain in your **LEFT KNEE** on average over the **LAST WEEK**?

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

No pain

Worst pain
imaginable

(b) How would you score the **FREQUENCY** of pain in your **LEFT KNEE** on average over the **LAST WEEK**?

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

None

Constant

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

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

No impact

Highest
impact
imaginable

Q94. RIGHT KNEE

(a) How would you score the **SEVERITY** of pain in your **RIGHT KNEE** on average over the **LAST WEEK**?

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

No pain

Worst pain
imaginable

(b) How would you score the **FREQUENCY** of pain in your **RIGHT KNEE** on average over the **LAST WEEK**?

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

None

Constant

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

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

No impact

Highest
impact
imaginable

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Q95. LEFT HIP

(a) How would you score the **SEVERITY** of pain in your **LEFT HIP** on average over the **LAST WEEK**?

No pain

Worst pain
imaginable

(b) How would you score the **FREQUENCY** of pain in your **LEFT HIP** on average over the **LAST WEEK**?

None

Constant

(c) 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

Highest
impact
imaginable

Q96. RIGHT HIP

(a) How would you score the **SEVERITY** of pain in your **RIGHT HIP** on average over the **LAST WEEK**?

No pain

Worst pain
imaginable

(b) How would you score the **FREQUENCY** of pain in your **RIGHT HIP** on average over the **LAST WEEK**?

None

Constant

(c) 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

Highest
impact
imaginable

Participant Study Number:

SECTION H: DISABILITIES OF THE ARM, SHOULDER AND HAND (DASH)

Injury related joint, bone and muscle conditions are common in both younger and older military populations due to the physical demands of military life. Even if you do not presently have pain, we would like to monitor your upper limb pain throughout the course of the study. This part of the questionnaire asks about symptoms as well as your ability to perform certain activities.

*Please answer every question based on your condition in the **LAST WEEK** by circling the appropriate number.*

If you did not have the opportunity to perform an activity in the past week, please make your best estimate on which response would be the most accurate.

*It DOESN'T MATTER which **HAND** or **ARM** you use to perform the activity.*

Q97. Please rate your ability to do the following activities in the LAST WEEK by circling the number which is the most appropriate response for you.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
(a) Open a tight or new jar	1	2	3	4	5
(b) Write	1	2	3	4	5
(c) Turn a key	1	2	3	4	5
(d) Prepare a meal	1	2	3	4	5
(e) Push open a heavy door	1	2	3	4	5
(f) Place an object on a shelf above your head	1	2	3	4	5
(g) Do heavy household jobs (e.g. wash walls, wash floors)	1	2	3	4	5
(h) Garden or do yard work	1	2	3	4	5
(i) Make a bed	1	2	3	4	5
(j) Carry a shopping bag or briefcase	1	2	3	4	5
(k) Carry a heavy object (over 10lbs/4.5kgs)	1	2	3	4	5
(l) Change a light bulb overhead	1	2	3	4	5
(m) Wash or blow dry your hair	1	2	3	4	5
(n) Wash your back	1	2	3	4	5
(o) Put on a pullover sweater	1	2	3	4	5
(p) Use a knife to cut food	1	2	3	4	5

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	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
(q) Recreational activities which require little effort (eg. card playing etc.)	1	2	3	4	5
(r) Recreational activities in which you take some force or impact through your arm, shoulder or hand (eg. golf, hammering, tennis etc.)	1	2	3	4	5
(s) Recreational activities in which you move your arm freely (eg. playing frisbee, badminton etc.)	1	2	3	4	5
(t) Manage transportation needs (getting from one place to another)	1	2	3	4	5
(u) Sexual activities	1	2	3	4	5

Q98.		NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
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? (circle the number)		1	2	3	4	5

Q99.		NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
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? (circle the number)		1	2	3	4	5

Q100.	Please rate the severity of the following symptoms in the last week <i>(circle the number)</i>	NONE	MILD	MODERATE	SEVERE	EXTREME
(a)	Arm, shoulder or hand pain	1	2	3	4	5
(b)	Arm, shoulder or hand pain when you performed any specific activity	1	2	3	4	5
(c)	Tingling (pins and needles) in your arm, shoulder or hand	1	2	3	4	5
(d)	Weakness in your arm, shoulder or hand	1	2	3	4	5
(e)	Stiffness in your arm, shoulder or hand	1	2	3	4	5

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Q101. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand (circle the number)	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
	1	2	3	4	5

Q102. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem (circle the number)	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
	1	2	3	4	5

WORK MODULE

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).

Q103. Please indicate what your job/work is: _____

☐ I do not work. If you have ticked this box, please skip this section and go to **Q105 (p.32)**.

Q104. During the past week did you have any difficulty: (circle the number)	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
(a) Using your usual technique for your work?	1	2	3	4	5
(b) Doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
(c) Doing your work as well as you would like?	1	2	3	4	5
(d) Spending your usual amount of time doing your work?	1	2	3	4	5

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SPORTS/PERFORMING ARTS MODULE

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 instrument or sport (or both), please answer with respect to that activity which is most important to you.

Q105. Please indicate which instrument or sport that is most important to you:

☐ I do not play an instrument or sport (please mark an **X** in the box if this applies to you).
If you have put an **X** in this box you may skip **Q47** and go to **Section I (p.33)**.

Q106. During the past week did you have any difficulty: (circle the number)	NO	MILD	MODERATE	SEVERE	UNABLE
	DIFFICULTY	DIFFICULTY	DIFFICULTY	DIFFICULTY	
(a) Using your usual technique for playing your instrument or sport?	1	2	3	4	5
(b) Playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
(c) Playing your instrument or sport as well as you would like?	1	2	3	4	5
(d) Spending your usual amount of time practicing or playing your instrument or sport?	1	2	3	4	5

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SECTION I: PAIN LOCATION

Q107. In the 'human figure' below, please show us where your current joint pain, neck or back pain is by marking X in the appropriate boxes.

Right **Left**

Shoulder Shoulder

Elbow Elbow

Wrist Wrist

Thumb Hand or fingers Hand or fingers Thumb

Neck

Upper back

Lower back

Hip Hip

Groin

Knee Knee

Ankle Ankle

Foot Foot

Ball of foot or toes Ball of foot or toes

Participant Study Number:

SECTION J: PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

As you may have experienced or observed in your time in service, mental well-being is an incredibly important aspect of overall health. Please answer the following questions as honestly as possible.

All your answers to the questions in this questionnaire are treated with the utmost confidentiality.

Q108. Over the LAST 2 WEEKS , how often have you been bothered by any of the following problems? <i>(circle the number)</i>	Not at all	Several days	More than half the days	Nearly every day
(a) Little interest or pleasure in doing things	0	1	2	3
(b) Feeling down, depressed or hopeless	0	1	2	3
(c) Trouble falling or staying asleep or sleeping too much	0	1	2	3
(d) Feeling tired or having little energy	0	1	2	3
(e) Poor appetite or overeating	0	1	2	3
(f) Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
(g) Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
(h) 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	0	1	2	3
(i) Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

Q109. If you circled **ANY** problems, 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?
(please mark X in the box to indicate your answer)

Not at all difficult

☐

Somewhat difficult

☐

Very difficult

☐

Extremely difficult

☐

Participant Study Number: **A D V** /

SECTION K: GENERALIZED ANXIETY DISORDER (GAD-7) QUESTIONNAIRE

Q110. Over the LAST 2 WEEKS , how often have you been bothered by any of the following problems? (<i>circle the number</i>)	Not at all	Several days	More than half the days	Nearly every day
(a) Feeling nervous, anxious or on edge	0	1	2	3
(b) Not being able to stop or control worrying	0	1	2	3
(c) Worrying too much about different things	0	1	2	3
(d) Trouble relaxing	0	1	2	3
(e) Being so restless that it is hard to sit still	0	1	2	3
(f) Becoming easily annoyed or irritable	0	1	2	3
(g) Feeling afraid as if something awful might happen	0	1	2	3

Participant Study Number:

A	D	V
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SECTION L: HEALTH-RELATED QUALITY OF LIFE QUESTIONNAIRE (EQ-5D-5L)

Under each heading, please mark **X** in the ONE box that best describes your health **TODAY**.

Q111. MOBILITY

- | | |
|---|--------------------------|
| (a) I have no problems in walking about | <input type="checkbox"/> |
| (b) I have slight problems in walking about | <input type="checkbox"/> |
| (c) I have moderate problems in walking about | <input type="checkbox"/> |
| (d) I have severe problems walking about | <input type="checkbox"/> |
| (e) I am unable to walk about | <input type="checkbox"/> |

Q112. SELF-CARE

- | | |
|---|--------------------------|
| (a) I have no problem washing or dressing myself | <input type="checkbox"/> |
| (b) I have slight problems washing or dressing myself | <input type="checkbox"/> |
| (c) I have moderate problems washing or dressing myself | <input type="checkbox"/> |
| (d) I have severe problems washing or dressing myself | <input type="checkbox"/> |
| (e) I am unable to wash or dress myself | <input type="checkbox"/> |

Q113. USUAL ACTIVITIES

(e.g. work, study, housework, family or leisure activities)

- | | |
|--|--------------------------|
| (a) I have no problems doing my usual activities | <input type="checkbox"/> |
| (b) I have slight problems doing my usual activities | <input type="checkbox"/> |
| (c) I have moderate problems doing my usual activities | <input type="checkbox"/> |
| (d) I have severe problems doing my usual activities | <input type="checkbox"/> |
| (e) I am unable to do my usual activities | <input type="checkbox"/> |

Q114. PAIN/DISCOMFORT

- | | |
|--|--------------------------|
| (a) I have no pain or discomfort | <input type="checkbox"/> |
| (b) I have slight pain or discomfort | <input type="checkbox"/> |
| (c) I have moderate pain or discomfort | <input type="checkbox"/> |
| (d) I have severe pain or discomfort | <input type="checkbox"/> |
| (e) I have extreme pain or discomfort | <input type="checkbox"/> |

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Q115. ANXIETY/DEPRESSION

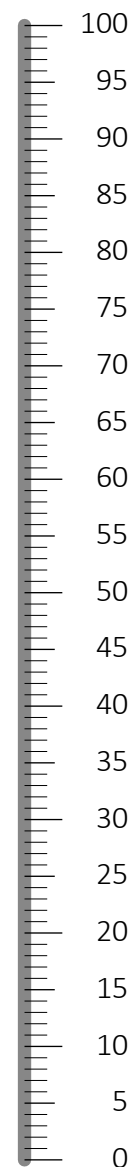
- (a) I am not anxious or depressed
- (b) I am slightly anxious or depressed
- (c) I am moderately anxious or depressed
- (d) I am severely anxious or depressed
- (e) I am extremely anxious or depressed

☐
☐
☐
☐
☐

Q116. 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.

The best health
you can imagine



YOUR HEALTH **TODAY** =

The worst health
you can imagine

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SECTION M: INTERNATIONAL PHYSICAL ACTIVITY QUESTIONNAIRE

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 yard 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, yard work, general maintenance and caring for your family. These are asked in Part 3.

Q117. Do you currently have a job or do any unpaid work outside your home?

☐

Yes

☐

No



SKIP TO PART 2: TRANSPORTATION (p. 40)

The next question 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.

Q118. During the **last 7 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.

_____ days per week

☐

No vigorous job-related physical activity



SKIP TO Q120

Participant Study Number: **A D V** /

Q119. How much time did you usually spend on one of those days doing **vigorous** physical activities as part of your work?

_____ hours per day

_____ minutes per day

Q120. 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.

_____ days per week

☐

No moderate job-related physical activity



SKIP TO Q122

Q121. How much time did you usually spend on one of those days doing **moderate** physical activities as part of your work?

_____ hours per day

_____ minutes per day

Q122. 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.

_____ days per week

☐

No job-related walking



SKIP TO PART 2: TRANSPORTATION (p. 40)

Q123. How much time did you usually spend on one of those days **walking** as part of your work?

_____ hours per day

_____ minutes per day

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PART 2: TRANSPORTATION PHYSICAL ACTIVITY

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

Q124. During the **last 7 days**, on how many days did you **travel in a motor vehicle** like a train, bus, car or tram?

_____ days per week

☐

No travelling in a motor vehicle



SKIP TO Q126

Q125. 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?

_____ hours per day

_____ minutes per day

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

Q126. During the **last 7 days** on how many days did you **bicycle** for at least 10 minutes at a time to go **from place to place**?

_____ days per week

☐

No bicycling from place to place



SKIP TO Q128

Q127. How much time did you usually spend on one of those days to **bicycle** from place to place?


_____ hours per day

_____ minutes per day

Participant Study Number: **A D V**/□□□□

Q128. 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**?

_____ days per week

☐ No walking from place to place  **SKIP TO PART 3: HOUSEWORK, HOUSE MAINTENANCE AND CARING FOR FAMILY**

Q129. How much time did you usually spend on one of those days **walking** from place to place?

_____ hours per day

_____ 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, yard work, 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.

Q130. During the **last 7 days** on how many occasions did you do **vigorous** physical activities like heavy lifting, chopping wood, shoveling snow or digging in the garden or yard?

_____ days per week

☐ No vigorous activity in garden or yard  **SKIP TO Q132**


Q131. How much time did you usually spend on one of those days doing **vigorous** physical activities in the garden or yard?

_____ hours per day

_____ minutes per day

Q132. 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 activities like carrying light loads, sweeping, washing windows and raking in the garden or yard?

_____ days per week

☐ No moderate activity in garden or yard  **SKIP TO Q134**

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Q133. How much time did you usually spend on one of those days doing **moderate** physical activities in the garden or yard?

_____ hours per day

_____ minutes per day

Q134. 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 floor and sweeping **inside your home**?

_____ days per week

☐

No moderate activity inside home



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

Q135. How much time did you usually spend on one of those days doing **moderate** physical activities inside your home?

_____ hours per day

_____ 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.

Q136. 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**?

_____ days per week

☐

No walking in leisure time



SKIP TO Q138

Q137. How much time did your usually spend on one of those days **walking** in your leisure time?


_____ hours per day

_____ minutes per day

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Q138. 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 bicycling or fast swimming **in your leisure time**?

_____ days per week

☐ No vigorous activity in leisure time  **SKIP TO Q140**

Q139. How much time did you usually spend on one of those days doing **vigorous** physical activities in your leisure time?

_____ hours per day

_____ minutes per day

Again, think about only those physical activities that you did for at least 10 minutes at a time.

Q140. During the **last 7 days** on how many days did you do **moderate** physical activities like bicycling at a regular pace, swimming at a regular pace and doubles tennis in **your leisure time**?

_____ days per week

☐ No moderate activity leisure time  **SKIP TO PART 5: TIME SPENT SITTING (p. 44)**

Q141. How much time did you usually spend on one of those days doing **moderate** physical activities in your leisure time?

_____ hours per day

_____ minutes per day

Participant Study Number:

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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.

Q142. During the **last 7 days** how much time did you usually spend **sitting** on a **weekday**?

_____ hours per day

_____ minutes per day

Q143. During the **last 7 days** how much time did you usually spend **sitting** on a **weekend day**?

_____ hours per day

_____ minutes per day

Participant Study Number: **A D V** /

SECTION N: PCL CHECKLIST

All your answers to the questions in this questionnaire are treated with the utmost confidentiality. We would like you to answer all questions as honestly as you can.

Q144. Below is a list of problems that people sometimes have in response to stressful life experiences. Please read each one carefully, then mark an **X** in ONE of the boxes to the right to indicate how much you have been bothered by that problem in the **PAST MONTH**.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
(a)	Repeated, disturbing memories, thoughts or images of a stressful experience from the past?	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
(b)	Repeated, disturbing dreams of a stressful experience from the past?	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
(c)	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
(d)	Feeling very upset when something reminded you of a stressful experience from the past?	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
(e)	Having physical reactions (e.g. heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
(f)	Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it?	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
(g)	Avoiding activities or situations because they reminded you of a stressful experience from the past?	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
(h)	Trouble remembering important parts of a stressful experience from the past?	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
(i)	Loss of interest in activities that you used to enjoy?	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
(j)	Feeling distant or cut off from other people?	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

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		Not at all	A little bit	Moderately	Quite a bit	Extremely
(k)	Feeling emotionally numb or being unable to have loving feelings for those close to you?	0	1	2	3	4
(l)	Feeling as if your future will somehow be cut short?	0	1	2	3	4
(m)	Trouble falling or staying asleep?	0	1	2	3	4
(n)	Feeling irritable or having angry outbursts?	0	1	2	3	4
(o)	Having difficulty concentrating?	0	1	2	3	4
(p)	Being 'super alert' or watchful or on guard?	0	1	2	3	4
(q)	Feeling 'jumpy' or easily startled?	0	1	2	3	4

Participant Study Number: **A D V**/□□□□

SECTION O: ALCOHOL INTAKE

Q145. Alcohol use can affect your health and can interfere with certain medications and treatments, so it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Circle the answer that best describes your reply to each question.

(a)	How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
(b)	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
(c)	How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(d)	During the past year, how often have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(e)	During the past year, how often have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(f)	During the past year, how often have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(g)	During the past year, how often have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(h)	During the past year, how often have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(i)	Have you or someone else been injured because of your drinking?	No		Yes but not in the past year		Yes during the past year
(j)	Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes but not in the past year		Yes during the past year

Participant Study Number:

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SECTION P: ASEX SCALE (ARIZONA SEXUAL EXPERIENCE SCALE)

All your answers to the questions in this questionnaire are treated with the utmost confidentiality. We would like you to answer all questions as honestly as you can.

Q146. The following questions are intended for ALL participants in the study regardless of your current sexual activity or practice method. If you are not sexually active and/or have not current desire for sexual activity we would be grateful if you would still complete the following questions. Your answers will remain confidential so please be honest.

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

A. How strong is your sex drive?

Extremely strong	Very strong	Somewhat strong	Somewhat weak	Very weak	No sex drive
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. How easily are you sexually aroused (turned on)?

Extremely easily	Very easily	Somewhat easily	Somewhat difficult	Very difficult	Never aroused
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Can you easily get and keep an erection?

Extremely easily	Very easily	Somewhat easily	Somewhat difficult	Very difficult	Never
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. How easily can you reach orgasm?

Extremely easily	Very easily	Somewhat easily	Somewhat difficult	Very difficult	Never reach orgasm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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E. Are your orgasms satisfying?

Extremely satisfying	Very satisfying	Somewhat satisfying	Somewhat unsatisfying	Very unsatisfying	Can't reach orgasm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Participant Study Number:

A	D	V
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SECTION Q: EMPLOYMENT AND EDUCATION/TRAINING HISTORY

Mark an **X** in **ONE** box that best describes your answer to each question.

Q147. Are you still serving in the military? Yes ☐ No ☐

If Yes, please go to Section R (p. 53)

If No, please answer the following questions

Q148. Are you currently in education or training?

- (a) Full-time ☐
- (b) Part-time ☐
- (c) Not at all ☐
- (d) Other, please explain? ☐ _____

Q149. Please list all your jobs or education/training courses you have attended since you left the military.

Dates	From ____/____/____ To ____/____/____
Employer/Institution	
Duties	
Job title/Course title	
Reason for leaving	

Dates	From ____/____/____ To ____/____/____
Employer/Institution	
Duties	
Job title/Course title	
Reason for leaving	

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Dates	From ____/____/____ To ____/____/____
Employer/Institution	
Duties	
Job title/Course title	
Reason for leaving	

Dates	From ____/____/____ To ____/____/____
Employer/Institution	
Duties	
Job title/Course title	
Reason for leaving	

Dates	From ____/____/____ To ____/____/____
Employer/Institution	
Duties	
Job title/Course title	
Reason for leaving	

Participant Study Number: **A D V**/□□□□

Dates	From ____/____/____ To ____/____/____
Employer/Institution	
Duties	
Job title/Course title	
Reason for leaving	

Dates	From ____/____/____ To ____/____/____
Employer/Institution	
Duties	
Job title/Course title	
Reason for leaving	

Dates	From ____/____/____ To ____/____/____
Employer/Institution	
Duties	
Job title/Course title	
Reason for leaving	

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SECTION R: DRUG/MEDICATION HISTORY

All your answers to the questions in this questionnaire are treated with the utmost confidentiality. We would like you to answer all questions as honestly as you can.

RECREATIONAL MEDICATIONS (INCLUDING 'LEGAL HIGHS')

Q150. Have you ever taken any 'recreational' drugs including legal highs? Yes ☐ No ☐

If your answer is **No**, please go to '**Prescribed Medications**' section (p. 57).

If your answer is **Yes**, please answer the following questions.

Q151. Have you ever taken cocaine?

Yes ☐ No ☐

If no, please skip to Q156

Q152. When did you last use it?

_____ (days/months/years)
Please delete as applicable

Q153. How many years have you used it?

_____ (years)

Q154. How many days per month do you use it?

_____ (days)

Q155. Amount per session?

_____ (grams)

Q156. Have you ever taken ecstasy?

Yes ☐ No ☐

If no, please skip to Q161 (p. 54)

Q157. When did you last use it?

_____ (days/months/years)
Please delete as applicable

Q158. How many years have you used it?

_____ (years)

Q159. How many days per month do you use it?

_____ (days)

Q160. Amount per session?

_____ (pills/mg MDMA)

*NB: roughly 100 mg per pill

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Q161. Have you ever used cannabis?

Yes ☐ No ☐

If no, please skip to Q166

Q162. When did you last use it?

_____ (days/months/years)

Q163. How many years have you used it?

_____ (years)

Q164. How many days per month do you use it?

_____ (days)

Q165. How long does it take to smoke an eighth?

_____ (days)

Q166. Have you ever taken mephedrone?

Yes ☐ No ☐

If no, please skip to Q171

Q167. When did you last use it?

_____ (days/months/years)
Please delete as applicable

Q168. How many years have you used it?

_____ (years)

Q169. How many days per month do you use it?

_____ (days)

Q170. Amount per session?

_____ (grams)

Q171. Have you ever taken speed/amphetamine?

Yes ☐ No ☐

If no, please skip to Q176 (p. 55)

Q172. When did you last use it?

_____ (days/months/years)
Please delete as applicable

Q173. How many years have you used it?

_____ (years)

Q174. How many days per month do you use it?

_____ (days)

Q175. Amount per session?

_____ (grams)

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Q176. Have you ever used ketamine (as a recreational drug)? Yes ☐ No ☐
If no, please skip to Q181

Q177. When did you last use it? _____ (days/months/years)
Please delete as applicable

Q178. How many years have you used it? _____ (years)

Q179. How many days per month do you use it? _____ (days)

Q180. How long does it take to smoke an eighth? _____ (days)

Q181. Have you ever taken heroin? Yes ☐ No ☐
If no, please skip to Q186

Q182. When did you last use it? _____ (days/months/years)
Please delete as applicable

Q183. How many years have you used it? _____ (years)

Q184. How many days per month do you use it? _____ (days)

Q185. Amount per session? _____ (grams)

Q186. Have you ever taken speed/amphetamine? Yes ☐ No ☐
If no, please skip to Q191 (p.56)

Q187. When did you last use it? _____ (days/months/years)
Please delete as applicable

Q188. How many years have you used it? _____ (years)

Q189. How many days per month do you use it? _____ (days)

Q190. Amount per session? _____ (grams)

Participant Study Number: **A D V**/□□□□

Q191. Have you ever taken other recreational drugs (1)? Yes ☐ No ☐
If no, please skip to 'Prescribed Medications' section (p. 57)

Q192. Which drug? _____

Q193. When did you last use it? _____ (days/months/years)
Please delete as applicable

Q194. How many years have you used it? _____ (years)

Q195. How many days per month do you use it? _____ (days)

Q196. Amount per session? _____

Q197. Have you ever taken other recreational drugs (2)? Yes ☐ No ☐
If no, please skip to 'Prescribed Medications' section (p. 57)

Q198. Which drug? _____

Q199. When did you last use it? _____ (days/months/years)
Please delete as applicable

Q200. How many years have you used it? _____ (years)

Q201. How many days per month do you use it? _____ (days)

Q202. Amount per session? _____

Q203. Have you ever taken other recreational drugs (3)? Yes ☐ No ☐
If no, please skip to 'Prescribed Medications' section (p. 57)

Q204. Which drug? _____

Q205. When did you last use it? _____ (days/months/years)
Please delete as applicable

Q206. How many years have you used it? _____ (years)

Q207. How many days per month do you use it? _____ (days)

Q208. Amount per session? _____

Participant Study Number: **A****D****V**/□□□□

PRESCRIBED MEDICATIONS

Q209. Have you ever taken opioid analgesics? Yes ☐ No ☐

(e.g. oramorph, MST, tramadol)

*If no, please skip to **Q216***

Q210. Which drug? _____

If you are still taking this medication, please answer the following questions

Q211. Was this for short periods of time post-surgery/injury? Yes ☐ No ☐

If Yes, please answer the following

Q212. When did you last use it? _____ (days/months/years)
Please delete as applicable

Q213. How many years have you used it? _____ (years)

Q214. How many days per month do you use it? _____ (days)

Q215. Amount per day? _____

Q216. Have you ever taken other opioid analgesics? Yes ☐ No ☐

(e.g. oramorph, MST, tramadol)

*If no, please skip to **Q224 (p. 58)***

Q217. Which drug? _____

If you are still taking this medication, please answer the following questions

Q218. Was this for short periods of time post-surgery/injury? Yes ☐ No ☐

If Yes, please answer the following

Q219. When did you last use it? _____ (days/months/years)
Please delete as applicable

Q220. How many years have you used it? _____ (years)

Q221. How many days per month do you use it? _____ (days)

Q223. Amount per day? _____

Participant Study Number: **A D V** /

Q224. Have you ever taken other opioid analgesics? Yes ☐ No ☐

(e.g. oramorph, MST, tramadol)

*If no, please skip to **Q231***

Q225. Which drug? _____

If you are still taking this medication, please answer the following questions

Q226. Was this for short periods of time post-surgery/injury? Yes ☐ No ☐

If Yes, please answer the following

Q227. When did you last use it? _____ (days/months/years)
Please delete as applicable

Q228. How many years have you used it? _____ (years)

Q229. How many days per month do you use it? _____ (days)

Q230. Amount per day? _____

Q231. Have you ever taken anxiolytics? (e.g. diazepam, temazepam) Yes ☐ No ☐

(please list all drugs separately)

*If no, please skip to **Q238 (p. 59)***

Q232. Which drug? _____

If you are still taking this medication, please answer the following questions

Q233. Was this for short periods of time post-surgery/injury? Yes ☐ No ☐

If Yes, please answer the following

Q234. When did you last use it? _____ (days/months/years)
Please delete as applicable

Q235. How many years have you used it? _____ (years)

Q236. How many days per month do you use it? _____ (days)

Q237. Amount per day? _____

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Q238. Have you ever taken other anxiolytics? Yes ☐ No ☐

(e.g. diazepam, temazepam)

If no, please skip to Q250 (p. 57)

Q239. Which drug? _____

If you are still taking this medication, please answer the following questions

Q240. When did you last use it? _____ (days/months/years)
Please delete as applicable

Q241. How many years have you used it? _____ (years)

Q242. How many days per month do you use it? _____ (days)

Q243. Amount per day? _____

Q244. Have you ever taken other anxiolytics? Yes ☐ No ☐

(e.g. diazepam, temazepam)

If no, please skip to Q250 (p. 60)

Q245. Which drug? _____

If you are still taking this medication, please answer the following questions

Q246. When did you last use it? _____ (days/months/years)
Please delete as applicable

Q247. How many years have you used it? _____ (years)

Q248. How many days per month do you use it? _____ (days)

Q249. Amount per day? _____

Participant Study Number: **A****D****V**/□□□□

Q250. Have you ever taken anti-depressants? Yes ☐ No ☐

(e.g. fluoxetine, citalopram)

If no, please skip to the end of the questionnaire.

Q251. Which drug?

Q252. When did you last use it?

_____ (days/months/years)

Please delete as applicable

Q253. How many years have you used it?

_____ (years)

Q254. How many days per month do you use it?

_____ (days)

Q255. Amount per day?

Q256. Have you ever taken anti-depressants? Yes ☐ No ☐

(e.g. fluoxetine, citalopram)

Q257. Which drug?

Q258. When did you last use it?

_____ (days/months/years)

Please delete as applicable

Q259. How many years have you used it?

_____ (years)

Q260. How many days per month do you use it?

_____ (days)

Q261. Amount per day?

End of Questionnaire

Thank you for completing this questionnaire. Please hand it in to a Nurse/member of the ADVANCE study team.



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