

Chicago Southeast Diabetes Community Action Coalition
Form A.12

(Reviewed and Approved)

Quality of Life Questionnaire



Name: _____

- 1 = Pre-Test
- 2 = Post-Test
- 3 = Follow-up

Client Number: __ __ __ __ __ __ __
Date: __ __ __ __ __ __
Location: __ __

1. In general, would you say your health is: ? 1\Excellent ? 2\Very Good ? 3\Good ? 4\Fair ? 5\Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, gardening, or walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

- 4. Accomplished less than you would like 1\Yes 2\No
- 5. Were limited in the kind of work or other activities 1\Yes 2\No

During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)?

- 6. Accomplished less than you would like 1\Yes 2\No

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7. Didn't do work or other activities as carefully as usually 1\Yes 2\No

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work and outside the home and housework)?

Not at all A little bit Moderately Quite a bit Extremely

For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the <u>past 4 weeks</u> ?	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting with friends, relatives, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Interviewer: _____ Date: _____