David A. Steenblock, D.O., Inc.
Personalized Regenerative Medicine
187 Avenida La Pata
San Clemente, CA 92673

PATIENT NAME _____ **DATE** _____

QUALITY OF LIFE INSTRUMENT FOR CHRONIC DISEASE

Instructions: This questionnaire helps your doctor to know our feelings **about your health situation in the last week.** Your answers will help the doctor choose the appropriate treatment and rehabilitation for you. **There are no right or wrong answers.** Please read the following questions carefully, and circle the number that is most fitting to your situation according to your own feelings. If you are not sure how to answer some of the questions, choose the answer that is closest to your true feelings. The information that you provide will remain strictly confidential.

Physical, Psychological and Social Function

		Not at all	A Little	Moderately	Very Much	Significant
1	Could you take care of your daily needs? (e.g., eating, dressing, washing, using toilet?)	1	2	3	4	5
2	Did you have a good appetite?	1	2	3	4	5
3	Did you sleep well last week?	1	2	3	4	5
4	Could you undertake appropriate family roles last week (such as parent, husband or wife)?	1	2	3	4	5
5	Did you have good relations with your family last week?	1	2	3	4	5
6	Did you receive physical and emotional support from your family last week?	1	2	3	4	5
7	Did you have optimistic thoughts about your illness last week?	1	2	3	4	5
8	Were the treatments you received last week good for improving your health and well-being?	1	2	3	4	5
9	Did you get sufficient care and support from your friends and relatives last week?	1	2	3	4	5
	SUBTOTAL					

NAME _____ **DATE** _____

		Not at all	A Little	Moderately	Very Much	Significant
10	Did your illness affect your memory and concentration last week?	1	2	3	4	5
11	Did your illness affect your mental attitude causing negative thoughts?	1	2	3	4	5
12	Did you feel lonely and helpless last week?	1	2	3	4	5
13	Did you feel any pessimism or despair?	1	2	3	4	5
14	Did your illness cause any worry?	1	2	3	4	5
15	Did you feel fretful or irritable?	1	2	3	4	5
16	Did you feel nervous or anxious?	1	2	3	4	5
17	Did you consider stopping your medication last week because it may have side effects?	1	2	3	4	5
18	Did you think you were a burden to your family last week?	1	2	3	4	5
19	Did your illness make you feel humiliated last week?	1	2	3	4	5
20	Did you hide your emotions to others last week but continue to think about them when you were alone?	1	2	3	4	5
	PAGE SUBTOTAL					

NAME _____ DATE _____

		Not at all	A Little	Moderately	Very Much	Significant
21	Did your illness or treatments interfere with your work or house work last week?	1	2	3	4	5
22	Did you feel fatigue too much?	1	2	3	4	5
23	Did your illness reduce your caring and attention to the family last week?	1	2	3	4	5
24	Did you have any trouble walking four blocks or more?	1	2	3	4	5
25	Did you have any trouble walking up and down stairs?	1	2	3	4	5
26	Did your illness affect your participating in leisure activities that you like last week?	1	2	3	4	5
27	Did you take any medication to to maintain your daily activities?	1	2	3	4	5
28	Did you have a good appetite last week?	1	2	3	4	5
29	Did your illness affect your finances last week?	1	2	3	4	5
30	Did you feel any pain or discomfort?	1	2	3	4	5
31	Did your illness affect your sexual activities last week?	1	2	3	4	5
	PAGE SUBTOTAL					

PATEINT NAME _____

DATE _____

SCORING DONE BY _____

SCORING

		Not at all	A Little	Moderately	Very Much	Significant
First Page		1	2	3	4	5
	Subtotals (Significant as positive response)					
		5	4	3	2	1
1	Copy the same results here					

Second Page		1	2	3	4	5
2	**Subtotals** (Not at all as positive response)					
Third Page		1	2	3	4	5
3	**Subtotals** (Not at all as positive response)					
TOTAL (Add rows 1, 2 and 3)						