

# HEALTH ASSESSMENT QUESTIONNAIRE (HAQ-DI)©

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
<b><u>DRESSING &amp; GROOMING</u></b>				
<b>Are you able to:</b>				
Dress yourself, including shoelaces and buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>ARISING</u></b>				
<b>Are you able to:</b>				
Stand up from a straight chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>EATING</u></b>				
<b>Are you able to:</b>				
Cut your own meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift a full cup or glass to your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open a new milk carton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>WALKING</u></b>				
<b>Are you able to:</b>				
Walk outdoors on flat ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb up five steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

<input type="checkbox"/> Devices used for Dressing (button hook, zipper pull, etc.)	<input type="checkbox"/> Built up or special utensils	<input type="checkbox"/> Crutches
<input type="checkbox"/> Special or built up chair	<input type="checkbox"/> Cane	<input type="checkbox"/> Wheelchair
	<input type="checkbox"/> Walker	

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

<input type="checkbox"/> Dressing and grooming	<input type="checkbox"/> Arising	<input type="checkbox"/> Eating	<input type="checkbox"/> Walking
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Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
<b><u>HYGIENE</u></b>				
<b>Are you able to:</b>				
Wash and dry your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take a tub bath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get on and off the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**REACH**

<b>Are you able to:</b>				
Reach and get down a 5 pound object (such as a bag of sugar) from above your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend down to pick up clothing from the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**GRIP**

<b>Are you able to:</b>				
Open car doors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open previously opened jars?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn faucets on and off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ACTIVITIES**

<b>Are you able to:</b>				
Run errands and shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do chores such as vacuuming or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

<input type="checkbox"/> Raised toilet seat	<input type="checkbox"/> Bathtub bar	<input type="checkbox"/> Long-handled appliances for reach
<input type="checkbox"/> Bathtub seat	<input type="checkbox"/> Long-handled appliances in bathroom	<input type="checkbox"/> Jar opener (for jars previously opened)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

<input type="checkbox"/> Hygiene	<input type="checkbox"/> Reach	<input type="checkbox"/> Gripping and opening things	<input type="checkbox"/> Errands and chores
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**Your ACTIVITIES:** To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

COMPLETELY

MOSTLY

MODERATELY

A LITTLE

NOT AT ALL

**Your PAIN:** How much pain have you had IN THE PAST WEEK?

On a scale of 0 to 100 (where zero represents “no pain” and 100 represents “severe pain”), please record the number below.

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**Your HEALTH:** Please rate how well you are doing on a scale of 0 to 100 (0 represents “very well” and 100 represents “very poor” health), please record the number below.

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