

Patient Questionnaire

Please complete the questions below, and then the 3 short screening tools on the following pages.

AFFIX
PATIENT ID
LABEL

If you do not understand any of the questions, or you have trouble reading them, please ask for help.

PATIENT TO COMPLETE THIS SECTION	Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>								
	How old are you now?									
	How old were you when you first had symptoms of your neurological condition?									
	Are you taking any antidepressant medication(s) at the moment?	Yes <input type="checkbox"/> No <input type="checkbox"/>								
	Are you having any “talking therapy” for depression or anxiety at the moment? (e.g. CBT, psychotherapy, counselling)	Yes <input type="checkbox"/> No <input type="checkbox"/>								
	Are you working at the moment?	Yes, full time <input type="checkbox"/> Yes, part time <input type="checkbox"/> No <input type="checkbox"/>								
	Do you have problems with remembering things, finding the right words, finding your way around, concentrating, or other thinking skills? Please put an “X” on this line to show how much trouble you have with these.									
	<table style="width: 100%; border: none;"> <tr> <td style="width: 10%;">No problems at all</td> <td style="width: 80%;"></td> <td style="width: 10%; text-align: right;">Very severe problems</td> </tr> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">10 20 30 40 50 60 70 80 90 100</td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center;"> </td> </tr> </table>		No problems at all		Very severe problems	0	10 20 30 40 50 60 70 80 90 100			
No problems at all		Very severe problems								
0	10 20 30 40 50 60 70 80 90 100									
How is your overall health? Please put an “X” on this line to show how you would rate your overall health state today .										
<table style="width: 100%; border: none;"> <tr> <td style="width: 45%;">Worst imaginable health state</td> <td style="width: 10%;"></td> <td style="width: 45%; text-align: right;">Best imaginable health state</td> </tr> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">10 20 30 40 50 60 70 80 90 100</td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center;"> </td> </tr> </table>		Worst imaginable health state		Best imaginable health state	0	10 20 30 40 50 60 70 80 90 100				
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You do not need to complete this section.

Your doctor or nurse will complete the questions below.

CLINICIAN TO COMPLETE	Diagnosis/Type of MS	RRMS <input type="checkbox"/> SPMS <input type="checkbox"/> PPMS <input type="checkbox"/> Uncertain <input type="checkbox"/> Not MS (specify).....	
	EDSS score (level of disability)		
	Currently taking DMT?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, which one(s)?
	Currently in relapse?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	What is your overall clinical impression of the patient's cognitive function? Please put an "X" on this line to indicate your overall impression.		

No problems at all Very severe problems

0 10 20 30 40 50 60 70 80 90 100

Screening Tool 2 - HADS

The following questions ask about how you have been feeling over the last **two weeks**.
Please put a tick in the box which is closest to how you have been feeling.

(tick closest choice)

(tick closest choice)

A1 I feel tense or "wound up"

Most of the time	<input type="checkbox"/>
A lot of the time	<input type="checkbox"/>
From time to time, occasionally	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

D1 I feel as if I am slowed down

Nearly all the time	<input type="checkbox"/>
Very often	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

A2 I get a sort of frightened feeling like "butterflies" in the stomach

Not at all	<input type="checkbox"/>
Occasionally	<input type="checkbox"/>
Quite often	<input type="checkbox"/>
Very often	<input type="checkbox"/>

D2 I still enjoy the things I used to enjoy

Definitely as much	<input type="checkbox"/>
Not quite as much?	<input type="checkbox"/>
Only a little	<input type="checkbox"/>
Hardly at all	<input type="checkbox"/>

A3 I get a sort of frightened feeling as if something awful is about to happen

Very definitely and quite badly	<input type="checkbox"/>
Yes, but not too badly	<input type="checkbox"/>
A little, but it doesn't worry me	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

D3 I have lost interest in my appearance

Definitely	<input type="checkbox"/>
I don't take so much care as I should	<input type="checkbox"/>
I may not take quite as much care	<input type="checkbox"/>
I take just as much care as ever	<input type="checkbox"/>

A4 I feel restless as if I have to be on the move

Very much indeed	<input type="checkbox"/>
Quite a lot	<input type="checkbox"/>
Not very much	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

D4 I can laugh and see the funny side of things

As much as I always could	<input type="checkbox"/>
Not quite so much now	<input type="checkbox"/>
Definitely not so much now	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

A5 Worrying thoughts go through my mind

A great deal of the time	<input type="checkbox"/>
A lot of the time	<input type="checkbox"/>
From time to time but not too often	<input type="checkbox"/>
Only occasionally	<input type="checkbox"/>

D5 I look forward with enjoyment to things

As much as I ever did	<input type="checkbox"/>
Rather less than I used to	<input type="checkbox"/>
Definitely less than I used to	<input type="checkbox"/>
Hardly at all	<input type="checkbox"/>

A6 I get sudden feelings of panic

Very often indeed	<input type="checkbox"/>
Quite often	<input type="checkbox"/>
Not very often	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

D6 I feel cheerful

Not at all	<input type="checkbox"/>
Not often	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>
Most of the time	<input type="checkbox"/>

A7 I can sit at ease and feel relaxed

Definitely	<input type="checkbox"/>
Usually	<input type="checkbox"/>
Not often	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

D7 I can enjoy a good book or radio or TV program

Often	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>
Not often	<input type="checkbox"/>
Very seldom	<input type="checkbox"/>

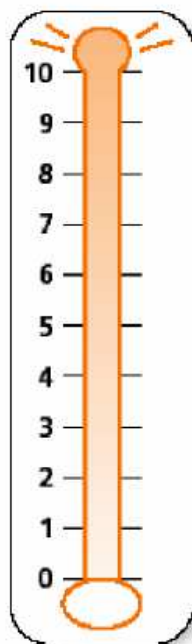
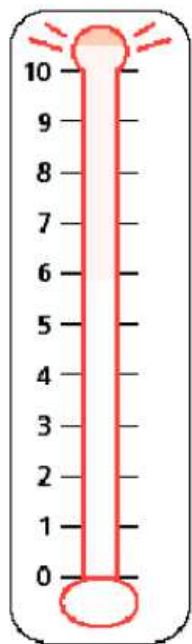
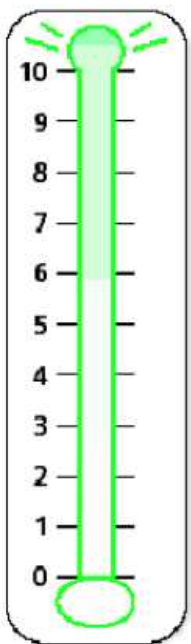
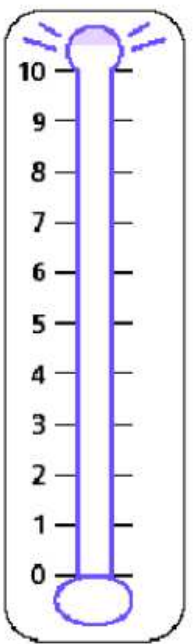
For our use

HADs -Anxiety subscale

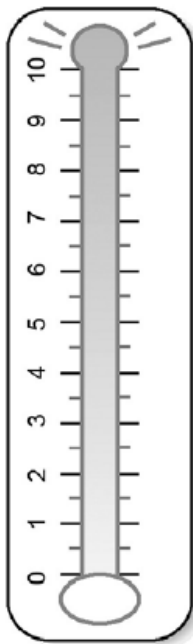
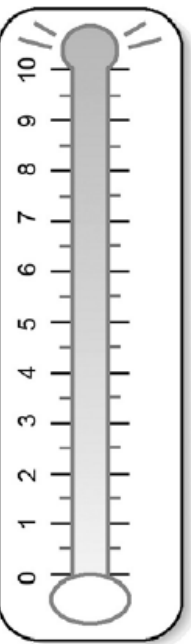
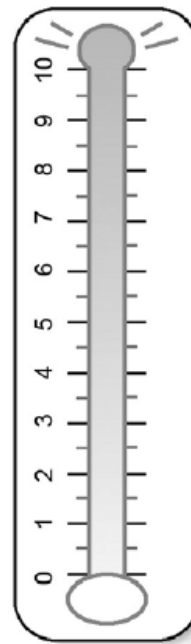
HADs -Depression subscale

Screening Tool 3 – ET7

In the first four columns, please mark the number (0-10) that best describes how much emotional upset you have been experiencing in the past **two weeks**, including today.

Emotional Upset			
1. Distress	2. Anxiety	3. Depression	4. Anger
10 = Extreme	10 = Extreme	10 = Extreme	10 = Extreme
			
0 = None	0 = None	0 = None	0 = None

In the next three columns please indicate how long you have been experiencing these emotional problems, how much impact they have had on you, and how much you need help for these.

Emotional Impact		
5. Duration	6. Burden	7. Need Help
10 = 10+ months	10 = Cannot function at all	10 = Desperately
		
0 = Just today	0 = No Effect on me	0 = Can manage myself