ADVANCED HEALTH SERVICES, LLC
Email: advancedhealth14@gmail.com
Website: www.OurAdvancedHealthServices.com
Phone: 561-596-7581 FAX: 561-355-5155

WELL-BEING QUESTIONNAIRE

DATE: _____/_____/_____ NAME: _____

MONTH DAY YEAR

Below is a list of statements that other people with your illness have said are important.

By circling one number per line, please indicate how true each statement has been for you during the past 7 days.

PHYSICAL WELL-BEING

	not at all	a little bit	somewhat	quite a bit	very much
1. I have a lack of energy…….	0	1	2	3	4
2. I have nausea……	0	1	2	3	4
3. Because of my physical condition, I have trouble meeting the needs of my family……	0	1	2	3	4
4. I have pain……...	0	1	2	3	4
5. I am bothered by side effects of treatment	0	1	2	3	4
6. I feel ill……..	0	1	2	3	4
7. I am forced to spend time in bed……..	0	1	2	3	4

Look at the above 7 questions, how much would you say your **PHYSICAL WELL-BEING** affects your quality of life? (circle one number)

0 1 2 3 4 5 6 7 8 9 10

Not at all **Very much so**

Notes: _____

_____

_____

_____

SOCIAL/FAMILY WELL-BEING

	not at all	a little bit	somewhat	quite a bit	very much
1. I feel distant from my friends…….	0	1	2	3	4
2. I get emotional support from my family.....	0	1	2	3	4
3. I get support from my friends and neighbors..	0	1	2	3	4
4. My family has accepted my illness…….	0	1	2	3	4
5. Family communication about my illness is poor…….	0	1	2	3	4
6. I feel close to my partner (or the person who is my main support) ..……	0	1	2	3	4
7. Have you been sexually active during the past year?.....	0	1	2	3	4
No ___ Yes ___ If yes: I am satisfied with my sex life……..	0	1	2	3	4

Looking at the above 7 questions, how much would you say your **SOCIAL/FAMILY WELLBEING** affects your quality of life? (circle one number)

0 1 2 3 4 5 6 7 8 9 10

Not at all **Very much so**

Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

RELATIONSHIP WITH DOCTOR

	not at all	a little bit	somewhat	quite a bit	very much
1. I have confidence in my doctor(s)……..	0	1	2	3	4
2. My doctor is available to answer my questions…….	0	1	2	3	4

Looking at the above 2 questions, how much would you say your **RELATIONSHIP WITH THE DOCTOR** affects your quality of life? (circle one number)

0 1 2 3 4 5 6 7 8 9 10

Not at all **Very much so**

EMOTIONAL WELL-BEING

	not at all	a little bit	somewhat	quite a bit	very much
1. I feel sad…….	0	1	2	3	4
2. I feel proud of how I'm coping with my illness…….	0	1	2	3	4
3. I am losing hope in the fight against my illness…….	0	1	2	3	4
4. I feel nervous……	0	1	2	3	4
5. I worry about dying……...	0	1	2	3	4
6. I worry that my condition will get worse……	0	1	2	3	4

Looking at the above 6 questions, how much would you say your **EMOTIONAL WELL-BEING** affects your quality of life? (circle one number)

0 1 2 3 4 5 6 7 8 9 10

Not at all **Very much so**

Notes: _____

_____

_____

_____

_____

FUNCTIONAL WELL-BEING

	not at all	a little bit	somewhat	quite a bit	very much
1. I am able to work (include work in home)….	0	1	2	3	4
2. My work (include work in home) is fulfilling…….	0	1	2	3	4
3. I am able to enjoy life……	0	1	2	3	4
4. I have accepted my illness…….	0	1	2	3	4
5. I am sleeping well……..	0	1	2	3	4
6. I am enjoying the things I usually do for fun	0	1	2	3	4
7. I am content with the quality of my life right now……	0	1	2	3	4

Looking at the above 7 questions, how much would you say your **FUNCTIONAL WELL-BEING** affects your quality of life? (circle one number)

0 1 2 3 4 5 6 7 8 9 10

Not at all **Very much so**

Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ADDITIONAL CONCERNS

	not at all	a little bit	somewhat	quite a bit	very much
1. I have swelling in my stomach area……	0	1	2	3	4
2. I am losing weight……..	0	1	2	3	4
3. I have control of my bowels……...	0	1	2	3	4
4. I have been vomiting……..	0	1	2	3	4
5. I am bothered by hair loss……..	0	1	2	3	4
6. I have a good appetite……	0	1	2	3	4
7. I like the appearance of my body……..	0	1	2	3	4
8. I am able to get around by myself…….	0	1	2	3	4
9. I am able to feel like a woman……..	0	1	2	3	4
10. I have cramps in my stomach area……	0	1	2	3	4
11. I am interested in sex……	0	1	2	3	4
12. I am concerned about my ability to have children…….	0	1	2	3	4

Looking at the above 12 questions, how much would you say these **ADDITIONAL CONCERNS** affect your quality of life? (circle one number)

0 1 2 3 4 5 6 7 8 9 10

Not at all **Very much so**

Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____