

QUALITY OF LIFE

PATIENT VERSION

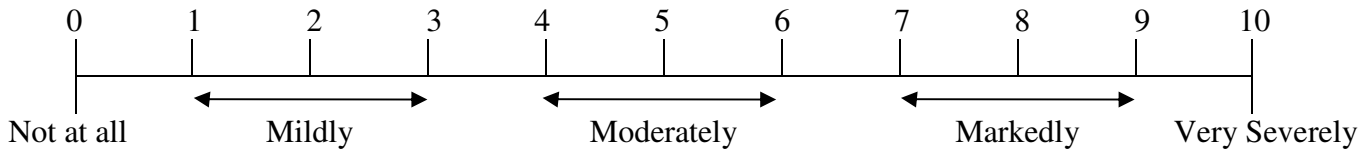
PATIENT NAME: _____; ID # _____; DATE: _____

CIRCLE A NUMBER THAT BEST DESCRIBES YOUR SITUATION NOW

WORK/SCHOOL

(If you are not in school and do not have full or part-time paid employment, mark “NA” beside the scale)

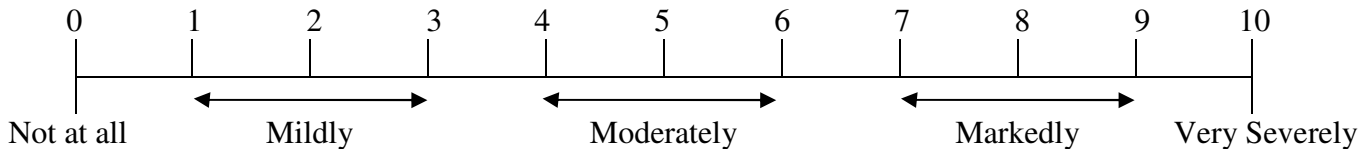
BECAUSE OF MY PROBLEMS, MY WORK IS IMPAIRED



SOCIAL LIFE / LEISURE ACTIVITIES

(with other people at parties, socializing, visiting, outings, clubs and entertaining)

BECAUSE OF MY PROBLEMS, MY SOCIAL LIFE / LEISURE IS IMPAIRED



FAMILY LIFE / HOME RESPONSIBILITIES

(relating to family members, paying bills, managing home, shopping and cleaning)

BECAUSE OF MY PROBLEMS, MY FAMILY LIFE / HOME RESPONSIBILITIES ARE IMPAIRED

