

APPENDIX 1: SKELETAL RELATED EVENTS (SRE) FORM
**Miami Cancer
Institute**
BAPTIST HEALTH SOUTH FLORIDA
Protocol: 2021-KOT-002
 Prophylactic Radiotherapy of Minimally Symptomatic Spinal Disease
(PROMISSED Trial)
Skeletal-Related Events (SRE) Assessment Form

Subject Initials: _____

Subject ID: _____

Visit Date: _____

Skeletal-Related Events (SRE) Assessment

How many lesions does this participant have enrolled? _____

Is the participant currently taking any opioid medication for pain relating to the lesion enrolled?

☐ YES ☐ NO

How many SREs is the participant experiencing? _____

 Please check off the SREs the participant is currently experiencing. – *Select all that apply.*

- ☐ Pathological fracture
☐ Spinal cord compression
☐ Palliative radiation
☐ Surgery

Please respond to the questions that pertain to the SREs checked off above.
Pathological Fracture

Date of event

____/____/____ / ____/____/____

Was the participant hospitalized because of this SRE?

☐ YES ☐ NO

If yes, date of hospitalization

____/____/____ / ____/____/____

Was the SRE identified through imaging?

☐ YES ☐ NO

If yes, date of scan

____/____/____ / ____/____/____

Is this SRE related to one or more of the lesions enrolled?

☐ YES ☐ NO

Please identify the lesion(s):

1. _____
2. _____
3. _____
4. _____
5. _____

Spinal Cord Compression

Date of event

 $\frac{\text{d}}{\text{d}} \frac{\text{d}}{\text{d}} / \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} / \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}}$

Was the participant hospitalized because of this SRE?

☐ YES ☐ NO

If yes, date of hospitalization

 $\frac{\text{d}}{\text{d}} \frac{\text{d}}{\text{d}} / \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} / \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}}$

Was the SRE identified through imaging?

☐ YES ☐ NO

If yes, date of scan

 $\frac{\text{d}}{\text{d}} \frac{\text{d}}{\text{d}} / \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} / \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}}$

Is this SRE related to one or more of the lesions enrolled?

☐ YES ☐ NO

1. _____ 2. _____

Please identify the lesion(s):

3. _____ 4. _____

5. _____

Palliative Radiation

Date of event

 $\frac{\text{d}}{\text{d}} \frac{\text{d}}{\text{d}} / \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} / \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}}$

Was the participant hospitalized because of this SRE?

☐ YES ☐ NO

If yes, date of hospitalization

 $\frac{\text{d}}{\text{d}} \frac{\text{d}}{\text{d}} / \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} / \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}}$

Was the SRE identified through imaging?

☐ YES ☐ NO

If yes, date of scan

 $\frac{\text{d}}{\text{d}} \frac{\text{d}}{\text{d}} / \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} / \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}}$

Is this SRE related to one or more of the lesions enrolled?

☐ YES ☐ NO

1. _____ 2. _____

Please identify the lesion(s):

3. _____ 4. _____

5. _____

Surgery

Date of event

 $\frac{\text{d}}{\text{d}} \frac{\text{d}}{\text{d}} / \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} \frac{\text{M}}{\text{M}} / \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}} \frac{\text{y}}{\text{y}}$

Primary reason for surgery – *Select one.*

- ☐ Severe bone pain
- ☐ Preventative treatment for pathological fracture
- ☐ To treat pathological fracture
- ☐ Other _____

Is this SRE related to one or more of the lesions enrolled?

☐ YES ☐ NO

Please identify the lesion(s):

1. _____
2. _____
3. _____
4. _____
5. _____

APPENDIX 2: LESION IDENTIFICATION WORKSHEET

**Miami Cancer
Institute**

BAPTIST HEALTH SOUTH FLORIDA

Protocol: 2021-KOT-002

Prophylactic Radiotherapy of Minimally Symptomatic Spinal Disease
(PROMISSED Trial)

Lesion Identification Worksheet

Subject Initials: _____

Subject ID: _____

Lesion Identification Worksheet

This worksheet is to document and to follow the ≤ 5 highest risk bone metastases identified at the time of randomization to receive either standard of care (Arm 1) or radiation (Arm 2).

Highest risk bone metastases definition per protocol: (*ensure consistency with protocol*)

1. Bulkiest sites of spinal osseous disease ≥ 2 cm
2. Disease at junctional level, including the thoracic apex (Occiput to C2, C7-T1, T12-L2, and L5-S1)
3. Disease with posterior element involvement, including interspinous, unilateral, or bilateral facet joints.
4. Vertebral body compression deformity $> 50\%$

Example:

Lesion location (detailed): left superior acetabulum

Highest risk bone metastases definition (1, 2, 3 or 4): 2

Date of imaging study: 6/11/2017

Image study type (CT, PET/CT, MRI): CT

Best image series/number (s) to identify the lesion: 101

Screenshot of the imaging study that identifies the lesion and its location (optional):



Lesion 1:

Lesion location (detailed): _____

Highest risk bone metastases definition:

Check one: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Date of imaging study: _____
(mm/dd/yyyy)

Image study type: ☐ CT ☐ CT/PET ☐ MRI

Screenshot of the imaging study that identifies the lesion and its location (optional)

Best image series/number(s) to identify the lesion:

Lesion 2:

Screenshot of the imaging study that identifies the lesion and its location (optional)

Lesion location (detailed): _____

Highest risk bone metastases definition:

Check one: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Date of imaging study: _____
(mm/dd/yyyy)

Image study type: ☐ CT ☐ CT/PET ☐ MRI

Best image series/number(s) to identify the lesion:

Lesion 3:

Screenshot of the imaging study that identifies the lesion and its location (optional)

Lesion location (detailed): _____

Highest risk bone metastases definition:

Check one: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Date of imaging study: _____
(mm/dd/yyyy)

Image study type: ☐ CT ☐ CT/PET ☐ MRI

Best image series/number(s) to identify the lesion:

Lesion 4:

Screenshot of the imaging study that identifies the lesion and its location (optional)

Lesion location (detailed): _____

Highest risk bone metastases definition:

Check one: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Date of imaging study: _____
(mm/dd/yyyy)

Image study type: ☐ CT ☐ CT/PET ☐ MRI

Best image series/number(s) to identify the lesion:

Lesion 5:

Screenshot of the imaging study that identifies the lesion and its location (optional)

Lesion location (detailed): _____

Highest risk bone metastases definition:

Check one: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Date of imaging study: _____
(mm/dd/yyyy)

Image study type: ☐ CT ☐ CT/PET ☐ MRI

Best image series/number(s) to identify the lesion:

Additional notes:

Form Completed by: _____ Date: _____

dd-MMM-yyyy

Site PI Signature: _____ Date: _____

dd-MMM-yyyy

APPENDIX 3: NUMERICAL PAIN RATING SCALE (NPRS)**Miami Cancer
Institute**

BAPTIST HEALTH SOUTH FLORIDA

Protocol: 2021-KOT-002Prophylactic Radiotherapy of Minimally Symptomatic Spinal Disease
(PROMISSED Trial)**Numeric Pain Rating Scale (NPRS) Form**

Subject Initials: _____

Subject ID: _____

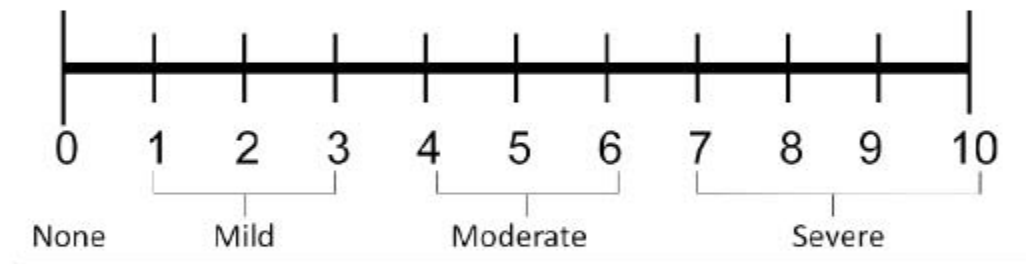
Visit Date: _____

Numeric Pain Rating Scale (NPRS)**General Information:**

- The participant is asked to make three pain ratings, corresponding to current, best, and worst pain experienced over the past 24 hours.
- The average of the 3 ratings was used to represent the patient's level of pain over the previous 24 hours.

Participant Instructions (adopted from McCaffery, Beebe et al. 1989):

"Please indicate the intensity of current, best, and worst pain levels over the past 24 hours on a scale of 0 (no pain) to 10 (worst pain imaginable)."



Current Pain Level _____

Best Pain Level _____

Worst Pain Level _____

Average Pain Level _____
(calculate)

Additional notes: _____

Form Completed by: _____ Date: _____
dd-MMM-yyyy

APPENDIX 4: NEUROLOGICAL EXAM FORM
**Miami Cancer
Institute**
BAPTIST HEALTH SOUTH FLORIDA
Protocol: 2021-KOT-002
 Prophylactic Radiotherapy of Minimally Symptomatic Spinal Disease
(PROMISSeD Trial)
Neurological Exam Form

Subject Initials: _____

Subject ID: _____

Visit Date: _____

Neurological Exam

 1. Tenderness over the spine – *Mark the spine level of tenderness on percussion.*

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
C1	C2	C3	C4	C5	C6	C7	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11	T12	
☐	☐	☐	☐	☐	☐	☐													
L1	L2	L3	L4	L5	Sacrum														

 2. Radiculopathy – *If present, mark all levels.*

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
C1	C2	C3	C4	C5	C6	C7	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10	T11	T12	
☐	☐	☐	☐	☐	☐	☐													
L1	L2	L3	L4	L5	Sacrum														

 3. Muscle strength of the extremities – *Mark 0-5 strength for each.*

Arm Muscles		Strength		Leg Muscles		Strength	
		Right	Left			Right	Left
Deltoid	C5/6			Iliopsoas	L2/3/4		
Biceps	C5/6			Quadriceps	L2/3/4		
Triceps	C6/7/8			Hamstrings	L4/5/S1		
Digit flex (hand grip)	C7/8/T1			Ant Tibialis	L4/L5		
Interossei	C8/T1			Gastrocnemius Soleus	L5/S1/2		

Modified MRC Grade of Muscle Strength

5 Normal strength

5- Equivocal, barely detectable weakness

3 Able to move against gravity without resistance

2 Active movement without gravity

4+ Definite, but slight weakness

1 Flicker or trace of movement

4 Able to move against gravity with resistance

0 No movement observed

4. Sensory change; Pinprick – *Mark normal or decreased.*

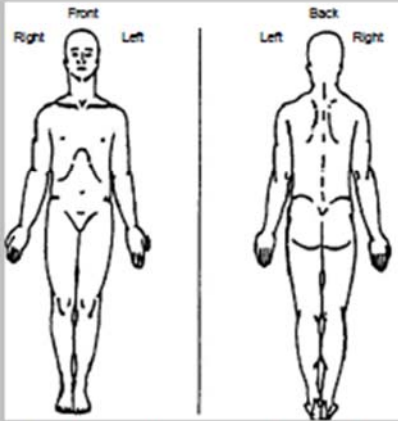
	Arm		Trunk		Leg	
	Right	Left	Right	Left	Right	Left
Normal						
Decreased						

Urinary incontinence (in participants who had initial abnormality or developed new symptoms) – *Select one.*☐ YES ☐ NOAnal sphincter tone (in participants who had initial abnormality or developed new symptoms) – *Select one.*
☐ Normal
☐ Decreased
☐ None

Additional notes: _____

Form Completed by: _____ Date: _____
dd-MMM-yyyySite PI Signature: _____ Date: _____
dd-MMM-yyyy

APPENDIX 5: BRIEF PAIN INVENTORY (BPI)

STUDY ID #: _____	DO NOT WRITE ABOVE THIS LINE	HOSPITAL #: _____
Brief Pain Inventory (Short Form)		
Date: ____/____/____		Time: _____
Name: _____		
Last	First	Middle Initial
1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?		
1. Yes 2. No		
2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.		
		
3. Please rate your pain by circling the one number that best describes your pain at its <u>worst</u> in the last 24 hours.		
012345678910 No Pain Pain as bad as you can imagine		
4. Please rate your pain by circling the one number that best describes your pain at its <u>least</u> in the last 24 hours.		
012345678910 No Pain Pain as bad as you can imagine		
5. Please rate your pain by circling the one number that best describes your pain on the <u>average</u>.		
012345678910 No Pain Pain as bad as you can imagine		
6. Please rate your pain by circling the one number that tells how much pain you have <u>right now</u>.		
012345678910 No Pain Pain as bad as you can imagine		
Page 1 of 2		

STUDY ID #: _____ DO NOT WRITE ABOVE THIS LINE HOSPITAL #: _____

Date: ____/____/____

Time: _____

Name: _____
Last First Middle Initial**7. What treatments or medications are you receiving for your pain?****8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.**0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No Complete
Relief Relief**9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:****A. General Activity**0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes**B. Mood**0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes**C. Walking Ability**0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes**D. Normal Work (includes both work outside the home and housework)**0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes**E. Relations with other people**0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes**F. Sleep**0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere Interferes**G. Enjoyment of life**0 1 2 3 4 5 6 7 8 9 10
Does not Completely
Interfere InterferesCopyright 1991 Charles S. Cleeland, PhD
Pain Research Group
All rights reserved

HOSPITAL N°: _____

Hora: _____

Inicial del segundo nombre

2. No

-

- Página 1 de 2

Fecha: ____/____/____ Hora: ____

Nombre: _____

Primer nombre Apellido Inicial del segundo nombre

7. ¿Qué tratamiento o medicación está recibiendo para el dolor?

8. En las últimas 24 horas, ¿hasta qué punto le han aliviado los tratamientos o la medicación para el dolor? Por favor, rodee con un círculo el porcentaje que corresponda al grado de **alivio** que ha sentido.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Ningún alivio Alivio total

9. Rodee con un círculo el número que mejor describa hasta qué punto el dolor lo ha afectado en los siguientes aspectos de la vida, durante las últimas 24 horas:

A. Actividad en general

0 1 2 3 4 5 6 7 8 9 10

No me ha afectado Me ha afectado por completo

B. Estado de ánimo

0 1 2 3 4 5 6 7 8 9 10

No me ha afectado Me ha afectado por completo

C. Capacidad de caminar

0	1	2	3	4	5	6	7	8	9	10
No me ha afectado										Me ha afectado por completo

D. Trabajo habitual (incluye tanto el trabajo fuera de casa como las tareas domésticas)

0 1 2 3 4 5 6 7 8 9 10

No me ha afectado Me ha afectado por completo

E. Relaciones con otras personas

0 1 2 3 4 5 6 7 8 9 10

No me ha afectado Me ha afectado por completo

F. Sueño

0	1	2	3	4	5	6	7	8	9	10
No me ha afectado									Me ha afectado por completo	

G. Disfrutar de la vida

0	1	2	3	4	5	6	7	8	9	10
No me ha afectado					Me ha afectado por completo					

APPENDIX 6: THE FUNCTIONAL ASSESSMENT OF CANCER THERAPY (FACT-G)**FACT-G (Version 4)**

Below is a list of statements that other people with your illness have said are important. Please circle or mark one number per line to indicate your response as it applies to the past 7 days.

<u>PHYSICAL WELL-BEING</u>		Not at all	A little bit	Some- what	Quite a bit	Very much
GP1	I have a lack of energy	0	1	2	3	4
GP2	I have nausea	0	1	2	3	4
GP3	Because of my physical condition, I have trouble meeting the needs of my family	0	1	2	3	4
GP4	I have pain	0	1	2	3	4
GP5	I am bothered by side effects of treatment	0	1	2	3	4
GP6	I feel ill	0	1	2	3	4
GP7	I am forced to spend time in bed	0	1	2	3	4

<u>SOCIAL/FAMILY WELL-BEING</u>		Not at all	A little bit	Some- what	Quite a bit	Very much
GS1	I feel close to my friends	0	1	2	3	4
GS2	I get emotional support from my family	0	1	2	3	4
GS3	I get support from my friends	0	1	2	3	4
GS4	My family has accepted my illness	0	1	2	3	4
GS5	I am satisfied with family communication about my illness	0	1	2	3	4
GS6	I feel close to my partner (or the person who is my main support)	0	1	2	3	4
Q1	<i>Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please mark this box ☐ and go to the next section.</i>					
GS7	I am satisfied with my sex life	0	1	2	3	4

FACT-G (Version 4)

Please circle or mark one number per line to indicate your response as it applies to the past 7 days.

<u>EMOTIONAL WELL-BEING</u>		Not at all	A little bit	Some- what	Quite a bit	Very much
GE1	I feel sad	0	1	2	3	4
GE2	I am satisfied with how I am coping with my illness.....	0	1	2	3	4
GE3	I am losing hope in the fight against my illness.....	0	1	2	3	4
GE4	I feel nervous.....	0	1	2	3	4
GE5	I worry about dying.....	0	1	2	3	4
GE6	I worry that my condition will get worse.....	0	1	2	3	4

<u>FUNCTIONAL WELL-BEING</u>		Not at all	A little bit	Some- what	Quite a bit	Very much
GF1	I am able to work (include work at home).....	0	1	2	3	4
GF2	My work (include work at home) is fulfilling.....	0	1	2	3	4
GF3	I am able to enjoy life.....	0	1	2	3	4
GF4	I have accepted my illness.....	0	1	2	3	4
GF5	I am sleeping well	0	1	2	3	4
GF6	I am enjoying the things I usually do for fun.....	0	1	2	3	4
GF7	I am content with the quality of my life right now.....	0	1	2	3	4

FACT-G (4ª Versión)

A continuación encontrará una lista de afirmaciones que otras personas con su misma enfermedad consideran importantes. Marque un solo número por línea para indicar la respuesta que corresponde a los últimos 7 días.

<u>ESTADO FÍSICO GENERAL DE SALUD</u>		Nada	Un poco	Algo	Mucho	Muchísimo
GP1	Me falta energía	0	1	2	3	4
GP2	Tengo náuseas.....	0	1	2	3	4
GP3	Debido a mi estado físico, tengo dificultad para atender a las necesidades de mi familia.	0	1	2	3	4
GP4	Tengo dolor.....	0	1	2	3	4
GP5	Me molestan los efectos secundarios del tratamiento.....	0	1	2	3	4
GP6	Me siento enfermo(a).....	0	1	2	3	4
GP7	Tengo que pasar tiempo acostado(a)	0	1	2	3	4

<u>AMBIENTE FAMILIAR Y SOCIAL</u>		Nada	Un poco	Algo	Mucho	Muchísimo
OS1	Me siento cercano(a) a mis amistades	0	1	2	3	4
OS2	Recibo apoyo emocional por parte de mi familia	0	1	2	3	4
OS3	Recibo apoyo por parte de mis amistades.....	0	1	2	3	4
OS4	Mi familia ha aceptado mi enfermedad	0	1	2	3	4
OS5	Estoy satisfecho(a) con la manera en que se comunica mi familia acerca de mi enfermedad.....	0	1	2	3	4
OS6	Me siento cercano(a) a mi pareja (o a la persona que es mi principal fuente de apoyo)	0	1	2	3	4
Q1	Sin importar su nivel actual de actividad sexual, conteste a la siguiente pregunta. Si prefiere no contestarla, marque esta casilla ☐ y continúe con la siguiente sección.					
OS7	Estoy satisfecho(a) con mi vida sexual.....	0	1	2	3	4

FACT-G (4ª Versión)

Marque un solo número por línea para indicar la respuesta que corresponde a los últimos 7 días.

<u>ESTADO EMOCIONAL</u>		Nada	Un poco	Algo	Mucho	Muchísimo
GE1	Me siento triste	0	1	2	3	4
GE2	Estoy satisfecho(a) de cómo me estoy enfrentando a mi enfermedad	0	1	2	3	4
GE3	Estoy perdiendo las esperanzas en la lucha contra mi enfermedad.....	0	1	2	3	4
GE4	Me siento nervioso(a)	0	1	2	3	4
GE5	Me preocupa morir	0	1	2	3	4
GE6	Me preocupa que mi enfermedad empeore.....	0	1	2	3	4

<u>CAPACIDAD DE FUNCIONAMIENTO PERSONAL</u>		Nada	Un poco	Algo	Mucho	Muchísimo
GF1	Puedo trabajar (incluya el trabajo en el hogar)	0	1	2	3	4
GF2	Mi trabajo me satisface (incluya el trabajo en el hogar)	0	1	2	3	4
GF3	Puedo disfrutar de la vida	0	1	2	3	4
GF4	He aceptado mi enfermedad	0	1	2	3	4
GF5	Duelmo bien	0	1	2	3	4
GF6	Disfruto con mis pasatiempos de siempre	0	1	2	3	4
GF7	Estoy satisfecho(a) con mi calidad de vida actual	0	1	2	3	4

APPENDIX 7: THE EUROQOL (EQ-5D)



Health Questionnaire

English version for the USA

Under each heading, please check the ONE box that best describes your health TODAY.

MOBILITY

- I have no problems walking ☐
- I have slight problems walking ☐
- I have moderate problems walking ☐
- I have severe problems walking ☐
- I am unable to walk ☐

SELF-CARE

- I have no problems washing or dressing myself ☐
- I have slight problems washing or dressing myself ☐
- I have moderate problems washing or dressing myself ☐
- I have severe problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

USUAL ACTIVITIES (*e.g. work, study, housework, family or leisure activities*)

- I have no problems doing my usual activities ☐
- I have slight problems doing my usual activities ☐
- I have moderate problems doing my usual activities ☐
- I have severe problems doing my usual activities ☐
- I am unable to do my usual activities ☐

PAIN / DISCOMFORT

- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

ANXIETY / DEPRESSION

- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐

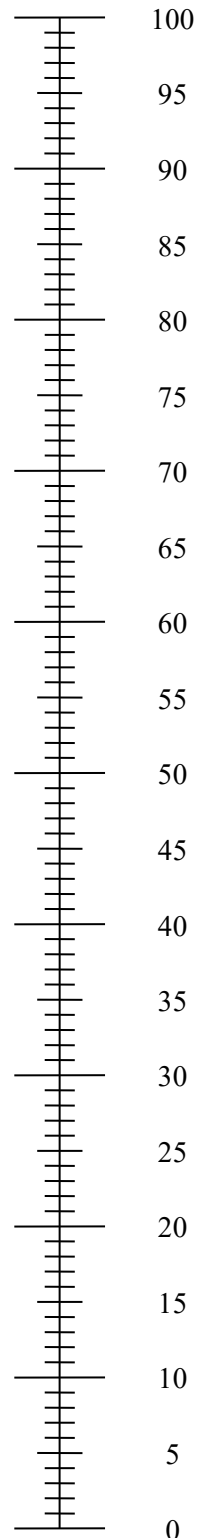
I am extremely anxious or depressed



- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =

The best health you
can imagine



The worst health
you can imagine



Cuestionario de Salud

Versión en español para los EE. UU.

(Spanish version for the USA)

Debajo de cada encabezamiento, marque UNA casilla, la que mejor describe su salud HOY.

MOVILIDAD

- No tengo problemas para caminar ☐
- Tengo problemas leves para caminar ☐
- Tengo problemas moderados para caminar ☐
- Tengo problemas graves para caminar ☐
- No puedo caminar ☐

CUIDADO PERSONAL

- No tengo problemas para lavarme o vestirme solo/a ☐
- Tengo problemas leves para lavarme o vestirme solo/a ☐
- Tengo problemas moderados para lavarme o vestirme solo/a ☐
- Tengo problemas graves para lavarme o vestirme solo/a ☐
- No puedo lavarme o vestirme solo/a ☐

ACTIVIDADES DE TODOS LOS DÍAS (Ej.: trabajar, estudiar, hacer las tareas domésticas, actividades familiares o actividades de ocio)

- No tengo problemas para realizar mis actividades de todos los días ☐
- Tengo problemas leves para realizar mis actividades de todos los días ☐
- Tengo problemas moderados para realizar mis actividades de todos los días ☐
- Tengo problemas graves para realizar mis actividades de todos los días ☐
- No puedo realizar mis actividades de todos los días ☐

DOLOR / MALESTAR

- No tengo dolor ni malestar ☐
- Tengo dolor o malestar leve ☐
- Tengo dolor o malestar moderado ☐
- Tengo dolor o malestar intenso ☐
- Tengo dolor o malestar extremo ☐

ANSIEDAD / DEPRESIÓN

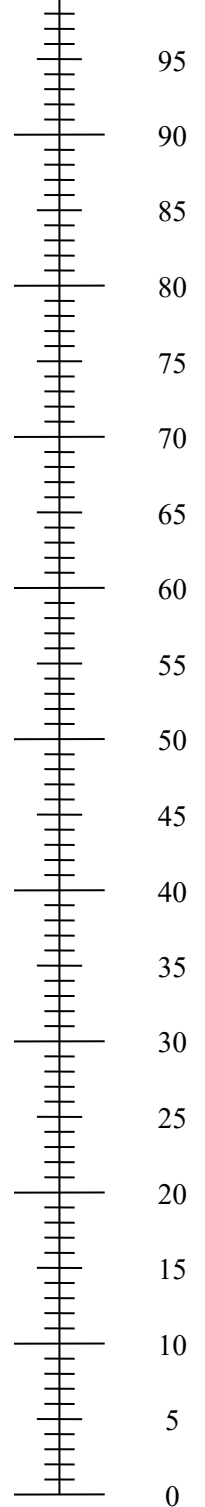
- No estoy ansioso/a ni deprimido/a ☐
- Estoy levemente ansioso/a o deprimido/a ☐
- Estoy moderadamente ansioso/a o deprimido/a ☐
- Estoy muy ansioso/a o deprimido/a ☐

Estoy extremadamente ansioso/a o deprimido/a



- Nos gustaría saber lo buena o mala que es su salud HOY.
- La escala está numerada de 0 a 100.
- 100 representa la mejor salud que se pueda imaginar.
0 representa la peor salud que se pueda imaginar.
- Por favor haga una X en la escala para indicar cuál es su estado de salud HOY.
- Ahora, por favor escriba en la casilla que encontrará a continuación el número que ha marcado en la escala.

SU SALUD HOY =

La mejor salud que
se pueda imaginar 100La peor salud que
se pueda imaginar