**Your Joint Care**

**1**

Questionnaire 1

Version 0.6 Date 26.02.18



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**Thank you for helping us to review the care and management of joint pain in our practice by filling out this questionnaire. Your answers are very important to us so that we can develop the way joint pain is managed and will help to support on-going care for patients like you**

**Please answer all the questions. The answers you give in the questionnaire will be treated in the strictest confidence.**

**When you have finished, please check that you have answered all of the questions and then return the questionnaire in the envelope enclosed. You do not need a stamp. Please return the completed questionnaire in the next two weeks. More details about this review are available in the letter enclosed.**

**If you have any more questions, please contact our nurse practitioner Hazel Lambourne on** 01584 872939

**Thank you for your help with the review of our services.**

# Section A. Your joint problem(s)

1. In the **past 3 months**, **on average**, **how intense were each of these pains** rated on a 0-10 scale where 0 is “no pain” and 10 is “pain as bad as could be”? (That is, your usual pain at times you were experiencing pain.)

***(Please cross one box only on each line. For pains that do not apply to you please put a cross in box 0 to indicate No Pain)***

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **No Pain** |  |  |  |  |  |  |  |  |  | **Pain as bad as could be** |
|  |  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |  |
| a. | Hip pain | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| b. | Knee pain | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| c. | Hand pain | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| d. | Foot pain | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |  |

1. The following questions concern your joint and muscle symptoms such as aches, pains and/or stiffness. Please focus on the particular health problem(s) for which you sought treatment from this service.

***(Please cross one box to indicate which statement best describes you over the last 2 weeks****)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **1. Pain/stiffness** during the **day**How severe was your usual joint or muscle pain and/or stiffness overall during the **day** in the last 2 weeks? | Not at all | Slightly | Moderately | Fairly severe | Very severe |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **2. Pain/stiffness** during the **night**How severe was your usual joint or muscle pain and/or stiffness overall during the **night** in the last 2 weeks? | Not at all | Slightly | Moderately | Fairly severe | Very severe |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **3. Walking**How much have your symptoms interfered with your ability to walk in the last 2 weeks? | Not at all | Slightly | Moderately | Severely | Unable to walk |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **4. Washing/Dressing**How much have your symptoms interfered with your ability to wash or dress yourself in the last 2 weeks? | Not at all | Slightly | Moderately | Severely | Unable to wash or dress myself |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **5. Physical activity levels**How much has it been a problem for you to do physical activities (e.g. going for a walk or jogging) to the level you want because of your joint or muscle symptoms in the last 2 weeks? | Not at all | Slightly | Moderately | Very much | Unable to do physical activities |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **6. Work/daily routine** How much have your joint or muscle symptoms interfered with your work or daily routine in the last 2 weeks (including work & jobs around the house)? | Not at all | Slightly | Moderately | Severely | Extremely |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **7. Social activities and hobbies**How much have your joint or muscle symptoms interfered with your social activities and hobbies in the last 2 weeks? | Not at all | Slightly | Moderately | Severely | Extremely |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |

**MSK-HQ – Questionnaire for joint, back, neck, bone and muscle symptoms**

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **8. Needing help**How often have you needed help from others (including family, friends or carers) because of your joint or muscle symptoms in the last 2 weeks? | Not at all | Rarely | Sometimes | Frequently | All the time |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **9. Sleep**How often have you had trouble with either falling asleep or staying asleep because of your joint or muscle symptoms in the last 2 weeks? | Not at all | Rarely | Sometimes | Frequently | Every night |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **10. Fatigue or low energy**How much fatigue or low energy have you felt in the last 2 weeks? | Not at all | Slight | Moderate | Severe | Extreme |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **11. Emotional well-being**How much have you felt anxious or low in your mood because of your joint or muscle symptoms in the last 2 weeks? | Not at all | Slightly | Moderately | Severely | Extremely |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **12. Understanding of your condition and any current treatment**Thinking about your joint or muscle symptoms, how well do you feel you understand your condition and any current treatment (including your diagnosis and medication)? | Completely | Very well | Moderately | Slightly | Not at all |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **13. Confidence in being able to manage your symptoms**How confident have you felt in being able to manage your joint or muscle symptoms by yourself in the last 2 weeks (e.g. medication, changing lifestyle)? | Extremely | Very | Moderately | Slightly | Not at all |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **14. Overall impact**How much have your joint or muscle symptoms bothered you overall in the last 2 weeks? | Not at all | Slightly | Moderately | Very much | Extremely |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |
| **15. Physical activity levels**In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your heart rate? *This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that is part of your job.* |
| None | 1 day | 2 days | 3 days | 4 days | 5 days | 6 days | 7 days |
| ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ | ⬜ |

**MSK-HQ – Questionnaire for joint, back, neck, bone and muscle symptoms**

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# Section B. Treating your joint problem(s)

1. There are several different treatments for joint pain. We would like to know what treatment, information or advice you have received from health professionals for your joint pain in the **past 3 months.**

***(Please cross one box for each question****)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|   |  | **Yes** | **No** | **Don’t remember** |
|  |  |  |  |  |
| a. | Have you been given information about joint pain from a health professional? | ⬜ | ⬜ | ⬜ |
| b. | Have you been given information about different treatment alternatives? | ⬜ | ⬜ | ⬜ |
| c. | Have you been given any advice on how you might help yourself to manage or deal with your joint pain? | ⬜ | ⬜ | ⬜ |
| d. | Have you been given any support on how you might help yourself to manage or deal with your joint pain? | ⬜ | ⬜ | ⬜ |
| e. | Have you been given information or advice about physical activity and exercise to help you with your joint pain? | ⬜ | ⬜ | ⬜ |
| f. | Have you been offered a referral to a health professional who can advise you about physical activity and exercise?  | ⬜ | ⬜ | ⬜ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Yes** | **No** | **Not overweight** |
|  |  |  |  |  |
| g. | Have you been advised to lose weight?  | ⬜ | ⬜ | ⬜ |
| h. | If you are overweight, have you been offered a referral to services for losing weight (e.g. a dietician or a weight-loss group)? | ⬜ | ⬜ | ⬜ |
|  |  | **Yes** | **No** | **No such problems** |
|  |  |  |  |  |
| i. | If you have had problems with daily activities, have these problems been assessed by a health professional?  | ⬜ | ⬜ | ⬜ |
| j. | If you have problems with walking, has your need for a walking aid (e.g. stick, crutch or walker) been assessed? | ⬜ | ⬜ | ⬜ |
| k. | If you have problems with other activities of daily living, has your need for appliances and aids (e.g. splints, assistive technology for cooking or personal hygiene, a special chair) been assessed?  | ⬜ | ⬜ | ⬜ |
|  |  | **Yes** | **No** | **No pain** |
|  |  |  |  |  |
| l. | If you have joint pain, has it been assessed by a health professional? | ⬜ | ⬜ | ⬜ |
| m. | If you have joint pain, was paracetamol the first pain killer recommended? | ⬜ | ⬜ | ⬜ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Yes** | **No** | **No prolonged severe pain** |
|  |  |  |  |  |
| n. | If you have prolonged severe joint pain, for which paracetamol does not provide pain relief, have you been offered stronger pain killing drugs (e.g. co-codamol, codeine, tramadol, co-proxamol, co-dydramol, dihydrocodeine)? | ⬜ | ⬜ | ⬜ |
|  |  | **Yes** | **No** | **Not taking such drugs** |
|  |  |  |  |  |
| o. | If you use anti-inflammatory drugs (e.g. ibuprofen (Nurofen, Brufen), diclofenac (Voltarol), naproxen (Naprosyn), celecoxib (Celebrex)), have you been given information about the effects and possible side-effects of the drug?  | ⬜ | ⬜ | ⬜ |
|  |  | **Yes** | **No** | **Not experienced such deterioration** |
|  |  |  |  |  |
| p. | If you have experienced an acute deterioration of your joint pain, have you been offered a steroid injection? | ⬜ | ⬜ | ⬜ |
|  |  | **Yes** | **No** | **Not severely troubled** |
|  |  |  |  |  |
| q. | If you are severely troubled by your joint pain, and exercise and medicine do not help, have you been offered a discussion about the benefits and risks of a joint replacement operation with a health care professional? | ⬜ | ⬜ | ⬜ |
|  |  | **Yes** | **No** | **Don’t remember** |
|  |  |  |  |  |
| r. | Have you discussed and agreed with your health professional when you will have a review of your joint pain and treatment? | ⬜ | ⬜ | ⬜ |

# Section C. Care and management of joint pain

1. How did you hear about the care and management of joint pain in our practice?

***(Please cross all boxes that apply)***

|  |  |
| --- | --- |
| 1. I saw a yellow Joint Pain poster...................................................................
 | ⬜ |
| 1. I saw a yellow Joint Pain leaflet.…..............................................................
 | ⬜ |
| 1. I saw it on the GP waiting room screen……………………………………….
 | ⬜ |
| 1. My Healthcare professional notified me………………………………………
 | ⬜ |
| 1. Word of mouth……………………………………………………………………
 | ⬜ |
| 1. Other (please specify below)……………………………………………………..
 | ⬜ |

# Section D. About you

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

1. What is your date of birth ⬜⬜ / ⬜⬜ / ⬜⬜ (Day / Month / Year)
2. Are you: ⬜ Female ⬜ Male
3. Today’s date: ⬜⬜ / ⬜⬜ / ⬜⬜ (Day / Month / Year)

1. Please state your ethnicity below:
2. How many days, weeks or months you were absent from work due to joint pains in the last 3 months?

***(Please enter a number in one of these boxes only)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Days** | **Weeks** | **Months** |  |
|  | ⬜ | ⬜ | ⬜ |  |

Audit ID No

# Consent

Thank you very much for completing this questionnaire. You received this because you have visited your healthcare professional and mentioned joint pain or joint problems.

**Please ensure that you have read the enclosed letter that came with this questionnaire**.

If you are unsure about anything please contact Nurse Practitioner **Hazel Lambourne on 01584 872939**

Please cross only one of the boxes below

⬜ **Yes,** I understand and agree for the information I give to be linked to

my medical records.

⬜ **No,** I do NOT want this information to be linked to my medical records

Now please sign and date below to confirm your decision.

Signature ………………………………………………... Date ………………………

Audit ID No

Questionnaire 1

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