

Insurance \_\_\_\_\_  
 Lab \_\_\_\_\_  
 Pharmacy \_\_\_\_\_



## RAPID 3 Patient Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

1. Please check (✓) the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without <b>ANY</b> <u>Difficulty</u>	With <b>SOME</b> <u>Difficulty</u>	With <b>MUCH</b> <u>Difficulty</u>	<b>UNABLE</b> <u>To Do</u>
a. Dress yourself, including tying shoelaces and doing buttons?	_____ 0	_____ 1	_____ 2	_____ 3
b. Get in and out of bed?	_____ 0	_____ 1	_____ 2	_____ 3
c. Lift a full cup or glass to your mouth?	_____ 0	_____ 1	_____ 2	_____ 3
d. Walk outdoors on flat ground?	_____ 0	_____ 1	_____ 2	_____ 3
e. Wash and dry your entire body?	_____ 0	_____ 1	_____ 2	_____ 3
f. Bend down to pick up clothing from the floor?	_____ 0	_____ 1	_____ 2	_____ 3
g. Turn regular faucets on and off?	_____ 0	_____ 1	_____ 2	_____ 3
h. Get in and out of a car, bus, train or airplane?	_____ 0	_____ 1	_____ 2	_____ 3
i. Walk two miles or three kilometers, if you wish?	_____ 0	_____ 1	_____ 2	_____ 3
j. Participate in recreational activities and sports, if you wish?	_____ 0	_____ 1	_____ 2	_____ 3

1. a-j FN (0-10)

1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

2. PN (0-10)

3. PTGL (0-10)

RAPID 3 (0-30)

2. How much pain have you had because of your condition OVER THE PAST WEEK?

Please indicate below how severe your pain has been:

NO ☐ PAIN AS BAD AS  
 PAIN 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 IT COULD BE

3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY ☐ VERY  
 WELL 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 POORLY