

# PROMIS®-57 Profile v2.1

Please respond to each question or statement by marking one box per row.

| <b><u>Physical Function</u></b> |                                                                                                                                        | <b>Without<br/>any<br/>difficulty</b> | <b>With a<br/>little<br/>difficulty</b> | <b>With<br/>some<br/>difficulty</b> | <b>With<br/>much<br/>difficulty</b> | <b>Unable<br/>to do</b>       |
|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------|-------------------------------------|-------------------------------------|-------------------------------|
| PFA11                           | Are you able to do chores such as vacuuming or yard work? .....                                                                        | <input type="checkbox"/><br>5         | <input type="checkbox"/><br>4           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>2       | <input type="checkbox"/><br>1 |
| PFA21                           | Are you able to go up and down stairs at a normal pace? .....                                                                          | <input type="checkbox"/><br>5         | <input type="checkbox"/><br>4           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>2       | <input type="checkbox"/><br>1 |
| PFA23                           | Are you able to go for a walk of at least 15 minutes? .....                                                                            | <input type="checkbox"/><br>5         | <input type="checkbox"/><br>4           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>2       | <input type="checkbox"/><br>1 |
| PFA53                           | Are you able to run errands and shop? .....                                                                                            | <input type="checkbox"/><br>5         | <input type="checkbox"/><br>4           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>2       | <input type="checkbox"/><br>1 |
|                                 |                                                                                                                                        | <b>Not at all</b>                     | <b>Very little</b>                      | <b>Somewhat</b>                     | <b>Quite a lot</b>                  | <b>Cannot do</b>              |
| PFC12                           | Does your health now limit you in doing two hours of physical labor? .....                                                             | <input type="checkbox"/><br>5         | <input type="checkbox"/><br>4           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>2       | <input type="checkbox"/><br>1 |
| PFB1                            | Does your health now limit you in doing moderate work around the house like vacuuming, sweeping floors or carrying in groceries? ..... | <input type="checkbox"/><br>5         | <input type="checkbox"/><br>4           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>2       | <input type="checkbox"/><br>1 |
| PFA5                            | Does your health now limit you in lifting or carrying groceries? .....                                                                 | <input type="checkbox"/><br>5         | <input type="checkbox"/><br>4           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>2       | <input type="checkbox"/><br>1 |
| PFA4                            | Does your health now limit you in doing heavy work around the house like scrubbing floors, or lifting or moving heavy furniture? ..... | <input type="checkbox"/><br>5         | <input type="checkbox"/><br>4           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>2       | <input type="checkbox"/><br>1 |
| <b><u>Anxiety</u></b>           |                                                                                                                                        |                                       |                                         |                                     |                                     |                               |
| <b>In the past 7 days...</b>    |                                                                                                                                        | <b>Never</b>                          | <b>Rarely</b>                           | <b>Sometimes</b>                    | <b>Often</b>                        | <b>Always</b>                 |
| EDANX01                         | I felt fearful .....                                                                                                                   | <input type="checkbox"/><br>1         | <input type="checkbox"/><br>2           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>4       | <input type="checkbox"/><br>5 |
| EDANX40                         | I found it hard to focus on anything other than my anxiety .....                                                                       | <input type="checkbox"/><br>1         | <input type="checkbox"/><br>2           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>4       | <input type="checkbox"/><br>5 |
| EDANX41                         | My worries overwhelmed me .....                                                                                                        | <input type="checkbox"/><br>1         | <input type="checkbox"/><br>2           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>4       | <input type="checkbox"/><br>5 |
| EDANX53                         | I felt uneasy .....                                                                                                                    | <input type="checkbox"/><br>1         | <input type="checkbox"/><br>2           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>4       | <input type="checkbox"/><br>5 |
| EDANX46                         | I felt nervous .....                                                                                                                   | <input type="checkbox"/><br>1         | <input type="checkbox"/><br>2           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>4       | <input type="checkbox"/><br>5 |
| EDANX07                         | I felt like I needed help for my anxiety ....                                                                                          | <input type="checkbox"/><br>1         | <input type="checkbox"/><br>2           | <input type="checkbox"/><br>3       | <input type="checkbox"/><br>4       | <input type="checkbox"/><br>5 |

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## Anxiety

### In the past 7 days...

|         |                      | Never                         | Rarely                        | Sometimes                     | Often                         | Always                        |
|---------|----------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| EDANX05 | I felt anxious ..... | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| EDANX54 | I felt tense.....    | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |

## Depression

### In the past 7 days...

|         |                                                   | Never                         | Rarely                        | Sometimes                     | Often                         | Always                        |
|---------|---------------------------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| EDDEP04 | I felt worthless.....                             | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| EDDEP06 | I felt helpless .....                             | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| EDDEP29 | I felt depressed .....                            | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| EDDEP41 | I felt hopeless .....                             | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| EDDEP22 | I felt like a failure.....                        | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| EDDEP36 | I felt unhappy .....                              | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| EDDEP05 | I felt that I had nothing to look forward to..... | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| EDDEP09 | I felt that nothing could cheer me up.....        | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |

## Fatigue

### During the past 7 days...

|     |                                                                | Not at all                    | A little bit                  | Somewhat                      | Quite a bit                   | Very much                     |
|-----|----------------------------------------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| HI7 | I feel fatigued .....                                          | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| AN3 | I have trouble <u>starting</u> things because I am tired ..... | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |

### In the past 7 days...

|          |                                                                                 |                               |                               |                               |                               |                               |
|----------|---------------------------------------------------------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| FATEXP41 | How run-down did you feel on average? .....                                     | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| FATEXP40 | How fatigued were you on average? .....                                         | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| FATEXP35 | How much were you bothered by your fatigue on average? .....                    | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| FATIMP49 | To what degree did your fatigue interfere with your physical functioning? ..... | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |

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## Fatigue

**In the past 7 days...**

|          |                                                                                           | Never                         | Rarely                        | Sometimes                     | Often                         | Always                        |
|----------|-------------------------------------------------------------------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| FATIMP3  | How often did you have to push yourself to get things done because of your fatigue? ..... | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| FATIMP16 | How often did you have trouble finishing things because of your fatigue? .....            | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |

## Sleep Disturbance

**In the past 7 days...**

|          |                                                     | Very poor                     | Poor                          | Fair                          | Good                          | Very good                     |
|----------|-----------------------------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Sleep109 | My sleep quality was .....                          | <input type="checkbox"/><br>5 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>1 |
|          |                                                     | Not at all                    | A little bit                  | Somewhat                      | Quite a bit                   | Very much                     |
| Sleep116 | My sleep was refreshing. ....                       | <input type="checkbox"/><br>5 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>1 |
| Sleep20  | I had a problem with my sleep .....                 | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| Sleep44  | I had difficulty falling asleep .....               | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| Sleep108 | My sleep was restless .....                         | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| Sleep72  | I tried hard to get to sleep .....                  | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| Sleep67  | I worried about not being able to fall asleep ..... | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| Sleep115 | I was satisfied with my sleep. ....                 | <input type="checkbox"/><br>5 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>1 |

## Ability to Participate in Social Roles and Activities

|               |                                                                                 | Never                         | Rarely                        | Sometimes                     | Usually                       | Always                        |
|---------------|---------------------------------------------------------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| SRPPER11_CaPS | I have trouble doing all of my regular leisure activities with others .....     | <input type="checkbox"/><br>5 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>1 |
| SRPPER18_CaPS | I have trouble doing all of the family activities that I want to do ..          | <input type="checkbox"/><br>5 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>1 |
| SRPPER23_CaPS | I have trouble doing all of my usual work (include work at home) .....          | <input type="checkbox"/><br>5 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>1 |
| SRPPER46_CaPS | I have trouble doing all of the activities with friends that I want to do ..... | <input type="checkbox"/><br>5 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>1 |

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## Ability to Participate in Social Roles and Activities

|               |                                                                                                  | Never                         | Rarely                        | Sometimes                     | Usually                       | Always                        |
|---------------|--------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| SRPPER15_CaPS | I have to limit the things I do for fun with others .....                                        | <input type="checkbox"/><br>5 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>1 |
| SRPPER28r1    | I have to limit my regular activities with friends .....                                         | <input type="checkbox"/><br>5 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>1 |
| SRPPER14r1    | I have to limit my regular family activities .....                                               | <input type="checkbox"/><br>5 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>1 |
| SRPPER26_CaPS | I have trouble doing all of the work that is really important to me (include work at home) ..... | <input type="checkbox"/><br>5 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>1 |

## Pain Interference

**In the past 7 days...**

|          |                                                                                          | Not at all                    | A little bit                  | Somewhat                      | Quite a bit                   | Very much                     |
|----------|------------------------------------------------------------------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| PAININ9  | How much did pain interfere with your day to day activities? .....                       | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| PAININ22 | How much did pain interfere with work around the home? .....                             | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| PAININ31 | How much did pain interfere with your ability to participate in social activities? ..... | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| PAININ34 | How much did pain interfere with your household chores? .....                            | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| PAININ12 | How much did pain interfere with the things you usually do for fun? .....                | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| PAININ36 | How much did pain interfere with your enjoyment of social activities? .....              | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| PAININ3  | How much did pain interfere with your enjoyment of life? .....                           | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |
| PAININ13 | How much did pain interfere with your family life? .....                                 | <input type="checkbox"/><br>1 | <input type="checkbox"/><br>2 | <input type="checkbox"/><br>3 | <input type="checkbox"/><br>4 | <input type="checkbox"/><br>5 |

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**Pain Intensity**

**In the past 7 days...**

|          |                                                |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |       |
|----------|------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------|
| Global07 | How would you rate your pain on average? ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |       |
|          |                                                | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10    |
|          |                                                | No                       |                          |                          |                          |                          |                          |                          |                          |                          |                          | Worst |
|          |                                                | pain                     |                          |                          |                          |                          |                          |                          |                          |                          |                          | pain  |