

# OASIS Assessment Tool

Client Name: \_\_\_\_\_

Birthdate (yy/mm/dd): \_\_\_\_\_

Family Dr.: \_\_\_\_\_

Appt Date: \_\_\_\_\_

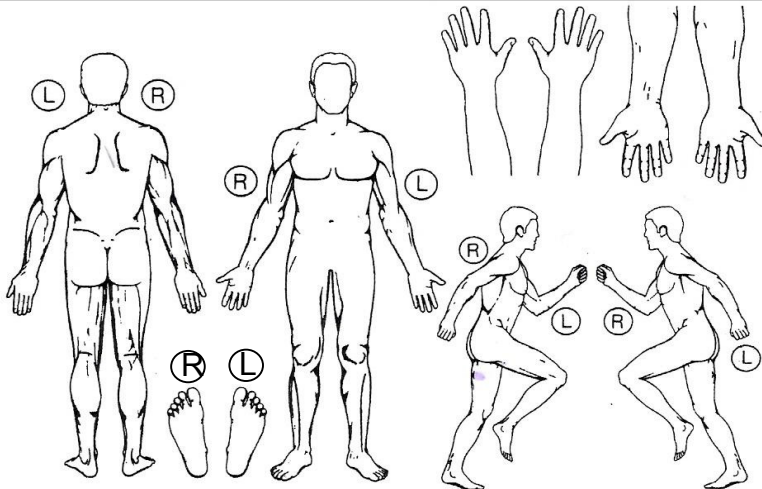
- Initial Assessment  
 Follow-up Assessment

## Client GOALS

Please indicate what your goals are by checking the appropriate boxes.

- ①  To manage my pain
- ②  To learn if I need surgery (joint replacement)
- ③  To learn how to manage my daily activities at home/work
- ④  To improve my ability to be active (specify activities): \_\_\_\_\_
- ⑤  To manage:
- Weight problems                       Medication                       Healthy Eating
- Sleep disturbances                       Stress / Anxiety / Depression
- ⑥  To get my home set up for safety and independence
- ⑦  Other (specify): \_\_\_\_\_

## Pain Inventory



On the diagram, shade in **all areas** where you feel pain. Put an "X" on the areas where it hurts the most.

Which joint has the most pain?

- Right Hip  
 Left Hip  
 Right Knee  
 Left Knee

When did the pain first start? \_\_\_\_\_

**What has been tried in the past to relieve the pain?**

What did you try? \_\_\_\_\_

How did it work? \_\_\_\_\_

Does pain affect your mood? (describe) \_\_\_\_\_

Client to Complete

Client to Complete

### Pain Inventory

**Answer the following questions as they relate to the joint with the most pain.**

The following questions concern the amount of joint stiffness (not pain) you are **currently** experiencing in your hips and/or knees. Stiffness is a sensation of restriction or slowness in the ease with which you move your joints. *(Please mark your answers with an "X")*

	None	Mild	Moderate	Severe	Extreme
How severe is your <b>stiffness</b> after first wakening in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How severe is your <b>stiffness</b> after sitting, lying or resting later in the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions concern the amount of pain you are **currently** experiencing due to osteo-arthritis in your hips and/or knees. For each situation, please enter the amount of pain recently experienced.

How much <b>pain</b> do you have:	None	Mild	Moderate	Severe	Extreme
Walking on a flat surface?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going up or down stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At night while in bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting or lying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing upright?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Activities of Daily Living (ADL) FUNCTIONS

The following questions concern your physical function. By this, we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you are currently experiencing due to arthritis in your hips and/or knees. *(Please mark your answers with an "X")*

What degree of difficulty do you have with:	None	Mild	Moderate	Severe	Extreme
Descending stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ascending stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from sitting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending to floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking on flat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going shopping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Putting on socks/stockings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking off socks/stockings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying in bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of bath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting on/off toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy domestic duties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light domestic duties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



### Activities of Daily Living (ADL) FUNCTIONS

The following questions concern any difficulty that you may be having at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

**Today**, do you or would you have any difficulty at all with: *(please mark your answers with an "X")*

Client to Complete

	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
(a) Any of your usual work, housework or school activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Your usual hobbies, recreational or sporting activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Getting into or out of the bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Walking between rooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Putting on your shoes or socks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Lifting an object, like a bag of groceries from the floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Performing light activities around your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Performing heavy activities around your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Getting into or out of a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Walking 2 blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Walking a mile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(m) Going up or down 10 stairs (about 1 flight of stairs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(n) Standing for 1 hour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(o) Sitting for 1 hour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(p) Running on even ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(q) Running on uneven ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(r) Making sharp turns while running fast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(s) Hopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(t) Rolling over in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(u) Getting on / off toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Client to Complete

#### Exercise

How far are you able to walk?     Unlimited     6 blocks     2-3 blocks     Indoors only     Bed to Chair to Toilet

**During the past week** (even if it was **not** a typical week), how much total time (for the **entire week**) did you spend on each of the following:

	None	Less than 30 minutes/ week	30/60 minutes/ week	1-3 hours/ week	More than 3 hours/ week
Walk for exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swimming or aquatic exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bicycling (including stationary exercise bike)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other aerobic exercise equipment (Stairmaster, rowing or skiing machine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other aerobic exercise (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**LIVING ARRANGEMENTS / WORK STATUS**

Client to Complete

Do you live alone?  Yes  No If no, with whom: \_\_\_\_\_

Are you the primary care giver for a dependent(s)?  Yes  No If yes, who: \_\_\_\_\_

Do you receive formal home supports (homecare, Veteran Affairs, other)?  Yes  No If yes, what: \_\_\_\_\_

Do you receive informal home support (family, friends)?  Yes  No If yes, from who: \_\_\_\_\_

Do you hire private care?  Yes  No If yes, what: \_\_\_\_\_

**Residence:**  Bungalow  Multi-level house  Apartment  Assisted living facility  Other: \_\_\_\_\_

**Stairs/Elevator:**  Elevator  Inside Stairs - # \_\_\_\_\_ Railing?  Y  N  Outside Stairs - # \_\_\_\_\_ Railing?  Y  N

Are you able to live on one level in your home if required?  Yes  No Comment:: \_\_\_\_\_

**Work Status:**  Working  On Disability  Retired Occupation (past/present): \_\_\_\_\_

If you have worked for pay in the past year, did you reduce the amount that you worked because of your arthritis? (Please check all that apply.)

No  Yes, I have completely stopped work because of my arthritis  Yes, I have missed \_\_\_\_\_ days of work because of my arthritis

Yes, I have reduced the number of hours I work by \_\_\_\_\_ hours per week.  Yes, I have reduced the number of weeks that I work by \_\_\_\_\_ weeks/year  Yes, I have changed the kind of work I do because of my arthritis

Yes, I have changed how I do my work.  Other (please specify): \_\_\_\_\_

If you have not worked for pay, are you: (Please check all that apply.)

Retired because of arthritis  Volunteering  Not working because of other medical reasons

Retired, but not because of arthritis  Staying at home to care for my family or house

Not working because of arthritis  Unemployed, but looking for work

Student  Other (please specify): \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_

Client to Complete

**ASSISTIVE DEVICES**

Which of the following are you **currently** using regularly at home?

None  Hand held shower  None  Walker: \_\_\_\_\_

Raised Toilet Seat  Reacher  Cane  Wheelchair

Toilet arm rests / frame  Long shoe horn  2 canes  Scooter

Bath/shower seat  Sock aid  Crutch/crutches  Other: \_\_\_\_\_

Wall / Tub grab bar  Raised Chair or Cushion

Commode  Other: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_

**Health Services Accessed**

**What health services have you used to help your arthritis? (Please answer for each service)**

Health Services	Have you ever used this service?		If NO, was it for any of the following reasons below? If YES, have you ever experienced any of the following problems below?						If YES, how many visits have you made in the past 6 months?	If YES, was the service helpful?
			Have had no problems with the service	Cost too much	Not available in my area	Did not know about the service	More than 3 months wait	Other		
Family Doctor	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Rheumatologist (arthritis specialist)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Orthopedic Surgeon	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Pharmacist	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Physiotherapy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Occupational Therapy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chiropractor	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Social Services	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mental Health Support	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Meal Delivery Service	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Handy Dart	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Disability Parking	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Exercise Program	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Weight Management Program	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dietitian or Nutritionist:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other (specify): _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of visits:	<input type="checkbox"/> No <input type="checkbox"/> Yes

**Quality of Life**

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today

**MOBILITY**

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

**SELF-CARE**

- I have no problems wash 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)

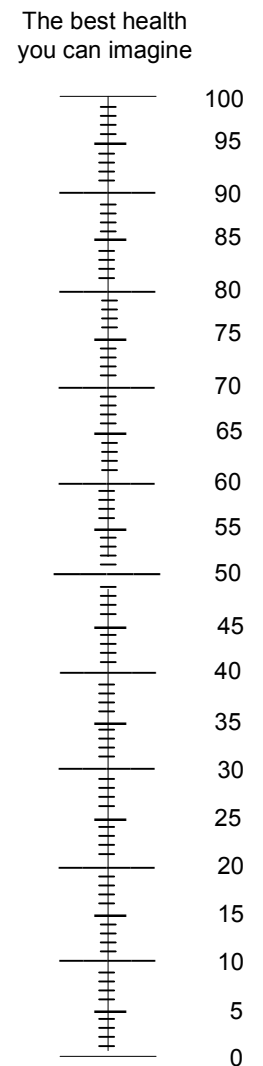
- I have no problems doing my usual activities
- I have slight problem doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

**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



Client to Complete

Client to Complete

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 1 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 =

## NUTRITIONAL HEALTH

The following questions will assist in determining your nutritional health.  
Read the statements below and mark your answers with an "X".

- |  |                             |                              |
|--|-----------------------------|------------------------------|
| 1. Is it hard for you to eat the kinds and amounts of food you like because of an illness or other conditions? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Do you eat less than two meals a day?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Do you have less than five servings of fruits, vegetables or juice a day?                                   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Do you eat or drink less than two servings of milk or dairy products a day?                                 | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Do you have more than two servings of beer, wine or liquor a day?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Do you have tooth, denture or mouth problems that make it hard to eat?                                      | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7. Do you ever run out of money for food?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 8. Do you eat alone most of the time?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 9. Do you take more than two different prescriptions or over the counter drugs a day?                          | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 10. Have you lost 10 pounds or more in the past six months without wanting to?                                 | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 11. Have you gained 10 pounds or more in the past six months without wanting to?                               | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 12. Is it hard for you to shop for food, cook or feed yourself?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

### Client Management of Symptoms

We would like to know how confident you are in doing certain activities. For each of the following questions, please circle the number that corresponds to your confidence that you can do the tasks regularly at the present time.

**How confident are you that you can....**

- |  |                         |   |   |   |   |   |   |   |   |   |    |                      |
|--|-------------------------|---|---|---|---|---|---|---|---|---|----|----------------------|
| 1. Reduce your physical discomfort or pain?  | Not at all<br>Confident | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Totally<br>Confident |
| 2. Keep the fatigue caused by your disease from interfering with the things you want to do?                      | Not at all<br>Confident | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Totally<br>Confident |
| 3. Keep the physical discomfort or pain of your disease from interfering with the things you want to do?         | Not at all<br>Confident | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Totally<br>Confident |
| 4. Keep any other symptoms or health problems you have from interfering with the things you want to do?          | Not at all<br>Confident | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Totally<br>Confident |
| 5. Control any symptoms or health problems you have so that they don't interfere with the things you want to do? | Not at all<br>Confident | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Totally<br>Confident |
| 6. Get information about your disease from community resources?  | Not at all<br>Confident | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Totally<br>Confident |

**Thank you for your information.**

***Please bring this completed form to your Assessment Appointment and give it to the OASIS Clinic Assistant.***