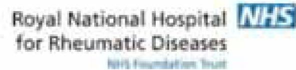


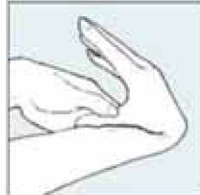

# Physiotherapy for Hypermobility Trial (PHyT)

**Month 4 Questionnaires**

| **ID:** | | | | |
|---|---|---|---|---|

| **DoB:** | | | | | 1 | 9 | | |
|---|---|---|---|---|---|---|---|---|

| **Today's Date:** | | | | | 2 | 0 | | |
|---|---|---|---|---|---|---|---|---|

Please find enclosed questionnaires that will help us to identify any changes in your condition

Please complete these and return in the pre-paid envelope supplied

Please note that it may take up to one hour to complete these questionnaires so please take your time and complete in more than one sitting

**Thank you so much for completing these questionnaires**

## Multi-Dimensional Health Assessment Questionnaire (R808-NP2)

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## Multi-Dimensional Health Assessment Questionnaire (R808-NP2)

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# BRISTOL IMPACT OF HYPERMOBILITY (BIOH) QUESTIONNAIRE

This questionnaire is designed to ask how hypermobility affects your day to day life. Please answer all of the questions and try not to think too much about your answer.

---

A. **During the past 7 days**, have you had pain in any of the following areas?

| | Yes | No |
|---|---|---|
| Shoulders | ☐ | ☐ |
| Elbows | ☐ | ☐ |
| Wrists | ☐ | ☐ |
| Hands | ☐ | ☐ |
| Hips | ☐ | ☐ |
| Knees | ☐ | ☐ |
| Ankles | ☐ | ☐ |
| Feet | ☐ | ☐ |
| Neck | ☐ | ☐ |
| Back | ☐ | ☐ |

---

B. We would like to know how often you have experienced pain and fatigue due to hypermobility during the **past 7 days.**
**Please circle the number which best reflects…**

1) your **average** level of pain during the **past 7 days**

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

2) your **worst** level of pain during the **past 7 days**

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

3) how much pain you have had **when walking** during the **past 7 days**

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

4) how much pain you have had **when resting** during the **past 7 days**

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

5) your **average** level of fatigue during the **past 7 days**

No fatigue 0 1 2 3 4 5 6 7 8 9 10 Totally exhausted

6) the **effect** fatigue has had on your life during the **past 7 days**

No effect 0 1 2 3 4 5 6 7 8 9 10 Large effect

7) how well you have **coped** with fatigue during the **past 7 days** *Reverse scored (0=10, 1=9, etc)

Not at all well 0 1 2 3 4 5 6 7 8 9 10 Very well

---

/70

C. Please tick the box which best describes how much, during the **past 7 days**, hypermobility has affected...

| | | Not at all[1] | A little[2] | Somewhat[3] | A lot[4] | Completely[5] |
|---|---|---|---|---|---|---|
| 8) | the footwear you have worn | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9) | the transport you have used | ☐ | ☐ | ☐ | ☐ | ☐ |

---

D. **How often.....**

| | | Never[1] | Occasionally[2] | Sometimes[3] | Often[4] | Always[5] |
|---|---|---|---|---|---|---|
| 10) | have you had unexpected pain (that was not an expected consequence of something you have done) during the past 7 days? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11) | has your wrist or hand given way, leading you to drop, or nearly drop something during the past 7 days? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12) | has your ankle, knee or hip given way, leading to a stumble or trip during the past 7 days? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13) | have you lost your balance during the past 7 days? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14) | have joints seized up during the past 7 days? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15) | has it felt like a joint has slipped out of place during the past 7 days? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16) | have you had muscle cramps or spasms during the past 7 days? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17) | has your sleep been disturbed due to pain or discomfort during the past 7 days? | ☐ | ☐ | ☐ | ☐ | ☐ |

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/50

E. How much difficulty have you had with the following tasks during the **past 7 days** due to hypermobility?

| | | Not difficult[1] | A little difficult[2] | Somewhat difficult[3] | Extremely difficult[4] | Completely impossible[5] |
|---|---|---|---|---|---|---|
| 18) | Bending or twisting | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19) | Squatting | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20) | Walking on uneven ground | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21) | Carrying a heavy bag, such as a shopping bag | ☐ | ☐ | ☐ | ☐ | ☐ |
| 22) | Reaching up to high shelves | ☐ | ☐ | ☐ | ☐ | ☐ |
| 23) | Pulling or pushing heavy doors | ☐ | ☐ | ☐ | ☐ | ☐ |
| 24) | Opening a tight or new jar | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | Not difficult[1] | A little difficult[2] | Somewhat difficult[3] | Extremely difficult[4] | Completely impossible[5] |
|---|---|---|---|---|---|---|
| 25) | Writing for more than 30 minutes | ☐ | ☐ | ☐ | ☐ | ☐ |
| 26) | Peeling or chopping vegetables | ☐ | ☐ | ☐ | ☐ | ☐ |
| 27) | Carrying a saucepan full of water | ☐ | ☐ | ☐ | ☐ | ☐ |

/50

F. How much discomfort would you have had after the following activities **during the past 7 days?**

| | | No discomfort[1] | Slightly uncomfortable[2] | Uncomfortable[3] | Painful[4] | Could not do it[5] |
|---|---|---|---|---|---|---|
| 28) | Standing up for more than 30 minutes | ☐ | ☐ | ☐ | ☐ | ☐ |
| 29) | Sitting in a chair for more than 30 minutes | ☐ | ☐ | ☐ | ☐ | ☐ |
| 30) | Standing up after sitting for more than 30 minutes | ☐ | ☐ | ☐ | ☐ | ☐ |
| 31) | Climbing several flights of stairs | ☐ | ☐ | ☐ | ☐ | ☐ |
| 32) | Going down several flights of stairs | ☐ | ☐ | ☐ | ☐ | ☐ |
| 33) | Walking at your own pace for a few miles | ☐ | ☐ | ☐ | ☐ | ☐ |
| 34) | Walking briskly for a few miles | ☐ | ☐ | ☐ | ☐ | ☐ |
| 35) | Wandering around shops or museums | ☐ | ☐ | ☐ | ☐ | ☐ |
| 36) | Bending or twisting | ☐ | ☐ | ☐ | ☐ | ☐ |
| 37) | Squatting | ☐ | ☐ | ☐ | ☐ | ☐ |

/50

G. **Please circle** the number which best indicates…

38) how much you have felt in control of the movement of your body and limbs during the **past 7 days**

0 1 2 3 4 5 6 7 8 9 10

Completely in control — Completely unable to control

39) how accurately you have been able to predict how you might feel in general over the **past 7 days**

0 1 2 3 4 5 6 7 8 9 10

Always able to predict — Completely unable to predict

40) how frustrated you have felt with hypermobility during the **past 7 days**

0 1 2 3 4 5 6 7 8 9 10

Not at all frustrated — Very frustrated

41) how strong your body and limbs have felt generally over the **past 7 days**

0 1 2 3 4 5 6 7 8 9 10

Very strong — Extremely weak

42) how 'tight', 'strong', 'held together' your body and limbs have felt generally during the **past 7 days**

0 1 2 3 4 5 6 7 8 9 10

Very tight — Extremely loose

43) how able you have felt to control your fatigue in the **past 7 days**

0 1 2 3 4 5 6 7 8 9 10

Completely in control — No control whatsoever

44) how much you have felt in control of your pain in the **past 7 days**

0 1 2 3 4 5 6 7 8 9 10

Completely in control — No control whatsoever

45) how much you have felt in control of your life in the **past 7 days**

0 1 2 3 4 5 6 7 8 9 10

Completely in control — No control whatsoever

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H. Thinking about what you are usually able to do, how much has hypermobility interfered with your activities during the **past 7 days?**

**Please circle** the number which best shows. . .

46) how much hypermobility has interfered with your daily activities during the **past 7 days?**

0 1 2 3 4 5 6 7 8 9 10

Not at all — Unable to do

47) how much difficulty you have had in carrying out your desired level of exercise during the **past 7 days**

0 1 2 3 4 5 6 7 8 9 10

No difficulty — Extreme difficulty

---

/100

I. Please tick the box which best describes your agreement with the following statements

| | | Strongly agree | Agree | Neither agree or disagree | Disagree | Strongly disagree |
|---|---|---|---|---|---|---|
| 48) | My body does not feel strong | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| 49) | I am concerned about my condition getting worse | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| 50) | I feel frustrated with my condition | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| 51) | My coordination is poor | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| 52) | I feel that I could trip or fall at any time | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| 53) | I can control the movement of my limbs | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| 54) | I feel that I can remain physically active | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| 55) | I feel that I can manage my condition | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |

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/40

**Thank you for taking the time to complete this questionnaire.**

**Total =** /360

## Visual Analogue Scales

Place a vertical mark on each line below to indicate how bad you feel your pain is today...

1. ... in the <u>most affected joint at rest</u>

No Pain |———————————| Pain as bad as it could be

2. ... in the <u>most affected joint on movement</u>

No Pain |———————————| Pain as bad as it could be

3. ... in <u>all your joints in general at rest</u>

No Pain |———————————| Pain as bad as it could be

4. ... in <u>all your joints in general on movement</u>

No Pain |———————————| Pain as bad as it could be

## Adverse Events

Please tell us about any untoward event, particularly if you feel has been related to taking part in the research or which was unexpected. We are particularly interested in events such as those which:

- required hospitalisation or prolongation of existing hospitalisation
- resulted in persistent or significant disability or incapacity
- other health event that you consider to be significant

## Exercise Self-Efficacy (Bandura 2006, adapted by Everett et al 2009)

A number of situations are described below that can make it hard to stick to an exercise routine. Please rate how sure you are that you can get yourself to exercise regularly (most days of the week).

*Rate your degree of confidence by recording a number from 0 (I cannot do this activity at all) to 10 (I am certain that I can do this activity successfully)*

| | **Confidence (0-10)** |
|---|---|
| When I am feeling tired | _____ |
| When I am feeling under pressure from work | _____ |
| During bad weather | _____ |
| After recovering from an injury that caused me to stop exercising | _____ |
| During or after experiencing personal problems | _____ |
| When I am feeling depressed | _____ |
| When I am feeling anxious | _____ |
| After recovering from an illness that caused me to stop exercising | _____ |
| When I feel physical discomfort when I exercise | _____ |
| After a vacation | _____ |
| When I have too much work to do at home | _____ |
| When visitors are present | _____ |
| When there are other interesting things to do | _____ |
| If I don't reach my exercise goals | _____ |
| Without support from my family or friends | _____ |
| During a vacation | _____ |
| When I have other time commitments | _____ |
| After experiencing family problems | _____ |

## EQ-5D-5L

Under each heading, please tick the ONE box that best describes your health 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 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 ☐

## RESOURCE USE QUESTIONNAIRE

In this section we will be asking you some questions about the health and care services you have used in the **past 4 months** since you joined the study. Please fill in all the questions to the best of your ability. We are interested in the services that have been provided by the NHS or social services. You can provide details of other health services that you have paid for in a separate section at the end of this questionnaire.

**1) In the last 4 months** you may have visited or received visits from a **physiotherapist** or an **occupational therapist** in the community, in hospital or at home. If so, please specify the services and number of visits or contacts in the **last 4 months.**

| Type of service | Was the therapist from the hospital or based in the community (i.e. GP practice)? | Number of visits or contacts |
|---|---|---|
| i. The physiotherapist visited me at home | Hospital ☐ Community ☐ | ☐☐ |
| ii. I visited the physiotherapist at the GP practice or hospital | Hospital ☐ Community ☐ | ☐☐ |
| iii. I had a phone consultation with the physiotherapist | Hospital ☐ Community ☐ | ☐☐ |
| iv. The occupational therapist visited me at home | Hospital ☐ Community ☐ | ☐☐ |
| v. I visited the occupational therapist at the GP practice or hospital | Hospital ☐ Community ☐ | ☐☐ |
| vi. I had a telephone consultation with the occupational therapist | Hospital ☐ Community ☐ | ☐☐ |
| vii. Other therapy services, for example podiatry (please specify): ........................................ | Hospital ☐ Community ☐ | ☐☐ |
| viii. Other therapy services, for example podiatry (please specify): ........................................ | Hospital ☐ Community ☐ | ☐☐ |

**2)** In the **last 4 months,** you may have required GP or other **health services available in the community** for reasons related to your hypermobility. **If so,** please specify the services and the number of visits or contacts in the **last 4 months**.

| | Type of service | Number of visits or contacts |
|---|---|---|
| i. | Visited the GP at the GP surgery | ☐☐ |
| ii. | The GP visited me at home | ☐☐ |
| iii. | Phoned GP for advice | ☐☐ |
| iv. | Visited a practice nurse at the GP surgery | ☐☐ |
| v. | Phoned GP practice nurse for advice | ☐☐ |
| vi. | Got a repeat prescription (without seeing doctor) | ☐☐ |
| xi. | Telephoned NHS direct | ☐☐ |
| xii | Accessed other GP-based services (please specify) ………………………………………………… | ☐☐ |

**3)** In the **last 4 months**, have you been to a hospital outpatient clinic appointment for reasons related to your hypermobility?

**3a)** Yes ☐ No ☐

**If yes**, can you please provide a few more details? Please do not include visits to the physiotherapist or occupational therapist that you have already told us about in question 1.

| **Name of Hospital** (b) | Number of visits (c) | Clinic or specialty visited **If known** **(d)** | Reason for the visit **(e)** |
|---|---|---|---|
| i. | ☐☐ | | |
| ii. | ☐☐ | | |
| iii. | ☐☐ | | |
| iv. | ☐☐ | | |

**4)** In the **last 4 months**, have you been **admitted to a hospital** or visited Accident and Emergency (**A&E**) department for reasons related to your hypermobility?

**4a)** Yes ☐ No ☐

**If yes**, can you please give a few more details?

| **Name of Hospital** (b) | Number of nights **spent in hospital** (c) | Ward visited **If known** **(d)** | Reason for the visit. If day case, write day case and if A&E, write A&E and a brief reason for the visit **(e)** |
|---|---|---|---|
| i. | ☐☐ | | |
| ii. | ☐☐ | | |
| iii. | ☐☐ | | |
| iv. | ☐☐ | | |

**5)** In the **last 4 months**, have you required any medications or preparations **prescribed by a doctor** for reasons related to your hypermobility?

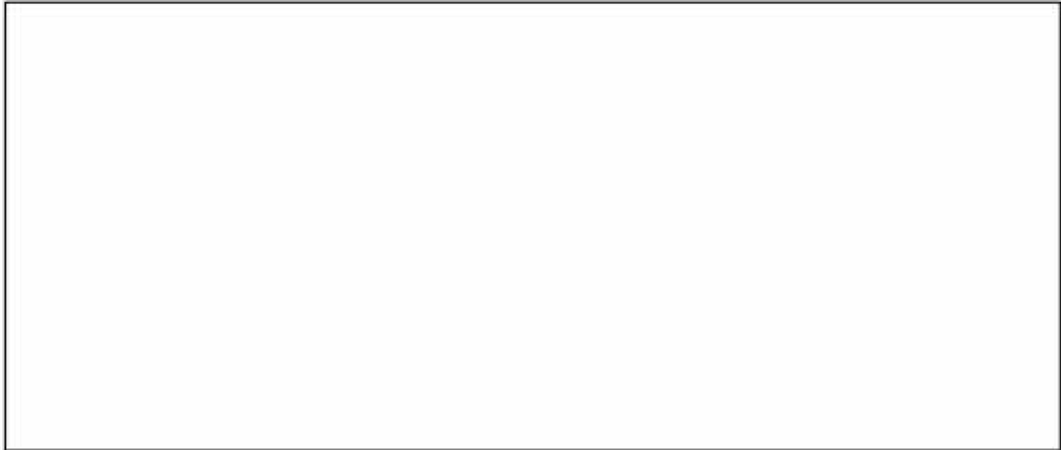
**5a)** Yes ☐ No ☐

**5b) If yes** How many prescriptions have you received? ☐☐

**If yes,** please describe

| **Name** of medicine and its **strength** *(copy name from the bottle/packet)* e.g. Ibuprofen 200mg (c) | (d) | What was the **daily dose**? (e) | For **how many weeks** have you taken this medicine? (if you for the whole 4 month period put 16 weeks) (f) |
|---|---|---|---|
| i. | mg | | ☐☐ weeks |
| ii. | mg | | ☐☐ weeks |
| iii. | mg | | ☐☐ weeks |
| iv. | mg | | ☐☐ weeks |
| v. | mg | | ☐☐ weeks |
| vi. | mg | | ☐☐ weeks |
| vii. | mg | | ☐☐ weeks |
| viii. | mg | | ☐☐ weeks |
| ix. | mg | | ☐☐ weeks |
| x. | mg | | ☐☐ weeks |

6) Please tell us about any other health or care services (including those not provided by the NHS that you have paid for) that you have used in the **last 4 months** that you have not told us about already in the questions above.



**Thank you for filling out these forms.**

**Please check you have not missed a page or any questions.**