

## Arthritis Impact Measurement Scales 2 (AIMS2-SF)

During the past four weeks ...	All Days	Most Days	Some Days	Few Days	No Days
1. How often were you physically able to drive a car or use public transportation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How often were you in a bed or chair for most of the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Did you have trouble doing vigorous activities such as running, lifting heavy objects, or participating in strenuous sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Did you have trouble either walking several blocks or climbing a few flights of stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Were you unable to walk unless assisted by another person or by a cane, crutches or walker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Could you easily write with a pen or pencil?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Could you easily button a shirt or blouse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Could you easily turn a key in a lock?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Could you easily comb or brush your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Could you easily reach shelves that were above your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Did you need help to get dressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Did you need help to get out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. How often did you have severe pain from your arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. How often did your morning stiffness last more than one hour from the time you woke up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. How often did your pain make it difficult for you to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. How often have you felt tense or high strung?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. How often have you been bothered by nervousness or your nerves?
18. How often have you been in low or very low spirits?
19. How often have you enjoyed the things you do?
20. How often did you feel like a burden to others?
21. How often did you get together with friends or relatives?
22. How often were you on the telephone with close friends or relatives?
23. How often did you go to a meeting of a church, club, team, or other groups?
24. Did you feel that your family or friends were sensitive to your personal needs?

**If you are unemployed, disabled, or retired, stop here.**

25. How often were you unable to do any paid work, house work or school work?
26. On the days you did work, how often did you have to work a shorter day?