University of Salford MANCHESTER

EDAQ

Office Use:

EDAQ:

Evaluation of Daily Activity Questionnaire

Optional:

NAME:_____ SITE:_____

Date of Birth:____/____/____ (dd/mm/yyyy) NHS/ Patient Number:_____

Therapist/Staff Name:_____ Date Completed:____/____/____ (dd/mm/yyyy)

The Evaluation of Daily Activity Questionnaire (EDAQ): parts 1 and 2.

Adapted by Alison Hammond, Alan Tennant, Sarah Tyson and Ulla Nordenskiöld from the Swedish EDAQ developed by Ulla Nordenskiöld PhD, Sahlgrenska Academy, University of Gothenburg, Sweden.

The EDAQ development and testing was funded by Arthritis Research UK grant 18497. Subsequently, the EDAQ was tested in other musculoskeletal conditions leading to minor modifications of the EDAQ. That work was supported by the United Kingdom Occupational Therapy Research Foundation

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The EDAQ parts 1 to 3 is also available at:

http://usir.salford.ac.uk/30754/

The EDAQ User Manual v2 plus Supplements and support materials are available at:

http://usir.salford.ac.uk/view/authors/10108.html#group_monograph

and the lead author's personal website www.profalisonhammond.com (in development)

EDAQ

The EDAQ (Evaluation of Daily Activity Questionnaire) helps us understand about your abilities and problems when doing your daily activities. You may have noticed that using aids, everyday gadgets/ equipment or even different ways of doing things (eg using two hands) reduces some of these problems. Sharing your problems and solutions with us, helps us to help you.

What to do:

There are **two parts.**

Part One asks about how arthritis is affecting you now.

Part Two asks about your ability to do your daily activities in the last two weeks.

Please answer **all** questions.

Please take your time filling in the questionnaire. Bring it with you to your next Therapy appointment.

In Part Two:

Think about your ability in the last **two weeks**. There is an example of how to complete this on page 7. **Please read these instructions and the example before filling in**.

Each page is divided into two sections. Each question should be answered **twice.**

Section A (left side of the page):

How you do the activity **without** using aids/ gadgets, alternate methods (e.g. two handed grip) or help?

- If you do not normally do the activity, tick "**Not Applicable**" (e.g. if you do not drive; or someone else always normally does that activity).
- If you no longer do the activity due to arthritis (i.e. someone else now has to do it for you), please tick "**Unable to do**."

Section B (right side of the page)

For **each** activity, please **tick** (✓) in the middle column either**:**

- **Yes:** if you use an aid/gadget or alternate method, then **always** complete Section B on the right side. Describe how you do it **with** an aid/gadget or alternate method. Then **tick (✓)** how easy/difficult this is.

- **No**: if you do **not** use an aid or alternate method. Do **not** complete the rest of section B.

Or

- **If you have help/ someone else does it for you** because of your health condition, please tick **(✓)** this column. Do **not** complete the rest of section B.

You can also contact us if you need further help.

Please leave the "score" column blank.

Part 1: Please ✓ the boxes below where relevant.

1. How long have you had your condition? _____ (years)

2. Are you working (paid/ unpaid), in education or planning to return to/start these? Yes ☐ No ☐

3. Have you taken part in a patient education programme to help you manage your arthritis?

Yes ☐ No ☐

4. If yes, how long was it for (in hours)? _____

For the following questions we ask you to <u>CIRCLE</u> the number below the line which best reflects your situation at the moment.

1.1. It is said that arthritis can be in an active or quiet phase. In which are you at the moment?

0 1 2 3 4 5 6 7 8 9 10

Extremely quiet — Extremely active

<u>Describe your:</u>

1.2. Mood:

0 1 2 3 4 5 6 7 8 9 10

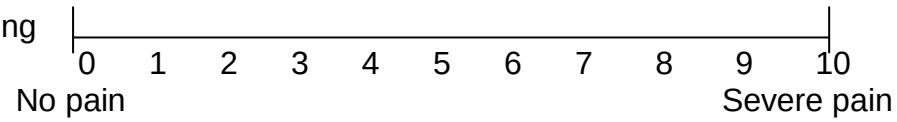
Very happy — Very unhappy

1.3. Pain when resting

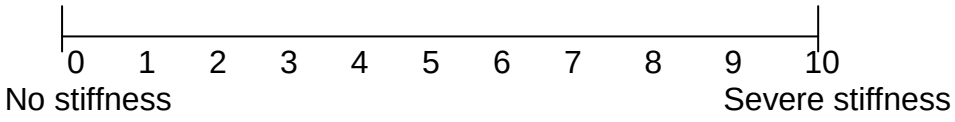
0 1 2 3 4 5 6 7 8 9 10

No pain — Severe pain

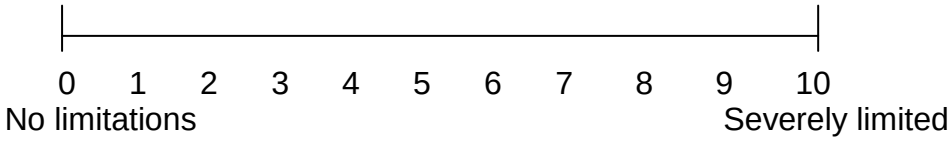
1.4. Pain when moving



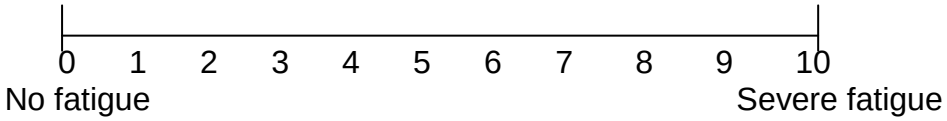
1.5. Stiffness



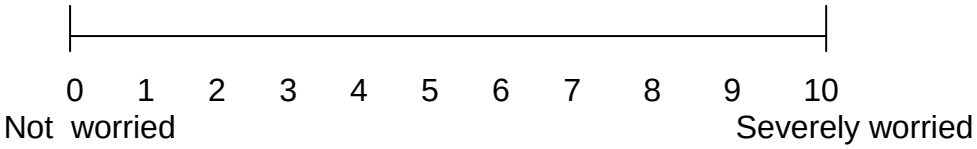
1.6. Limitations in joint movement



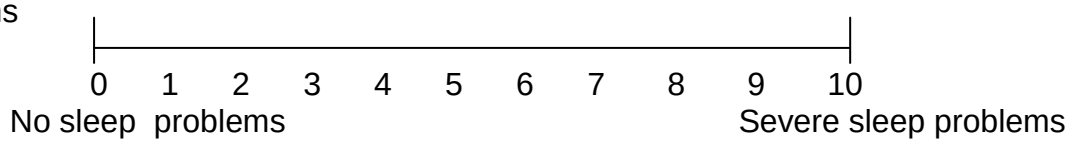
1.7. Fatigue



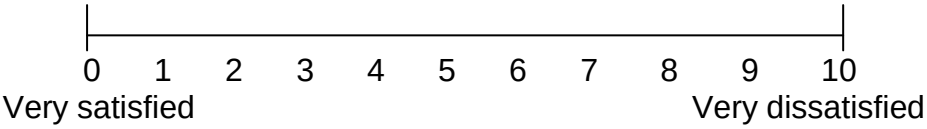
1.8. Worry



1.9. Sleep problems



1.10. Satisfaction with life



Instructions: Example of how to fill in the EDAQ

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

EXAMPLES:	**A.** How do you do it **without** an aid/gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1. Lift a cup/mug		✓						✓							
2. Turn taps				✓			✓			**Use tap turner/lever taps**	✓				
3. Pull out a plug			✓					✓							
4. Open a jar				✓			✓			**Jar opener**	✓				
5. Vacuum clean				✓			✓			**Take breaks, use two hands**		✓			
6. Put on/take off a coat				✓				✓							
7. Get in/out of bath					✓		✓			**Use a bath seat**		✓			
8. Climb ladder					✓			✓							
9. Drive a car	✓														
10. Clean windows				✓					✓						
Total Score: Section A =										**Total Score: Section B =**					

Part Two: Your ability to do everyday activities

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

1. EATING / DRINKING	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Lift a glass															
2.Lift a cup/mug															
3.Use a knife and fork															
4.Slice food (e.g. bread, cheese)															
5.Get the milk out of the fridge															
6.Open a milk carton/ plastic bottle and pour out															
7.Open a bottle top (e.g. lager)															
8.Open a screw top jar or bottle															
9.Open a tin or a ring-pull can															
10.Open a packet/pouch															
Total Score: Section A =										**Total Score: Section B =**					

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

2. IN THE BATHROOM/ PERSONAL CARE	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Get on and off the toilet															
2.Wipe yourself with toilet paper /clean self below															
3.Use tampons/ suppositories															
4.Flush the toilet															
5.Arrange your clothes after going to toilet															
6.Wash your hands															
7.Brush and comb your hair															
8.Brush your teeth															
9.Use a tube of toothpaste															
10.Open a medicine bottle/ blister pack															
11.Do your make up or shave															
12.Put on jewellery/watch															
Total Score: Section A =										**Total Score: Section B =**					

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

3. GETTING DRESSED /UNDRESSED	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Put on / take off a coat															
2.Pull clothes over your head															
3.Put on front-opening clothes															
4.Do up/undo buttons															
5.Pull clothes over your feet															
6.Do up /undo zips															
7.Put on tights/ socks															
8.Take shoes/ boots on and off															
9.Tie shoelaces															
10.Put on/take off gloves															
11.Fasten clothes at the back															
					Total Score: Section A =									**Total Score: Section B =**	

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

4. BATHING/ SHOWERING	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Get in and out of the bath															
2.Shower whilst standing															
3.Use shower controls /bath temperature mixers															
4.Turn taps *(any in home)*															
5.Wash your back and neck															
6.Dry your back and neck															
7.Wash and dry your feet															
8.Wash your hair															
9.Style/ blow-dry your hair															
10.Cut/file your finger nails															
11.Take care of your feet															
Total Score: Section A =										**Total Score: Section B =**					

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

5. COOKING	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Stand while working in the kitchen															
2.Set the table/ carry plates, cups etc															
3.Peel and chop vegetables															
4.Carry a full pan to/ from the cooker															
5.Drain water from a saucepan (e.g. vegetables, pasta)															
6.Remove heavy items (e.g. bag of sugar) from top cupboards															
7.Baking (eg. cakes, bread, pastry)															
8.Take things in/out of oven															

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

5. COOKING (continued)	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
9.Wash up															
10.Put crockery/pans etc into kitchen cupboards															
11.Use a kettle (e.g. fill, pour)															
12.Turn cooker knobs															
13.Open fridge door															
14.Prepare and cook a snack and/or a meal															
Total Score: Section A =										**Total Score: Section B =**					

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

6.MOVING AROUND IN DOORS	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Walk indoors (e.g. get to toilet/ bathroom; round kitchen)															
2.Open the front/ back door															
3.Lock and unlock doors															
4.Get to the front door in time to answer															
5.Get to the phone in time to answer															
6.Stand for longer periods															
7.Get up and down steps/ stairs															
8.Bend to floor/pick up items															
9.Reach up															
10.Kneel															
11.Carry heavy items around the house															
12.Manage heating (e.g. controls, woodburner, multifuel stove, open fire)															
Total Score: Section A =										**Total Score: Section B =**					

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

7. CLEANING THE HOUSE	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Make the bed															
2.Dust and wipe surfaces															
3.Sweep up/ mop floor															
4.Wring out a cloth															
5.Vacuum clean															
6.Open a window															
7.Clean windows															
8.Clean the bath and/or shower															
9.Heavy housework (e.g. move furniture, take down curtains)															
Total Score: Section A =										**Total Score: Section B =**					

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

8. LAUNDRY/ CLOTHES CARE	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Do the hand washing															
2.Use a washing machine (e.g. load and unload)															
3.Hang out washing															
4.Plug in and pull out a plug *(any in home)*															
5.Put up an ironing board															
6.Iron															
7.Do small repairs e.g. hemming, buttons															
8.Use scissors *(any in home)*															
9.Pick up pins/needles															
Total Score: Section A =										**Total Score: Section B =**					

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

9. MOVING AND TRANSFERS	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Get into and out of bed															
2.Turn over and sit up in bed															
3.Stand up from a chair without armrests															
4.Pull up bedclothes/duvet															
5.Getting a comfortable sleeping position															
6.Sit for longer periods (e.g. in a car, train)															
Total Score: Section A =										**Total Score: Section B =**					

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

10. COMMUNICATION	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Use a phone / mobile/ smartphone (*call/ text/ any functions)*															
2.Hold a book															
3.Write															
4.Handle money/ cards; use cash machine/pay by card															
5.Use a computer and mouse/ laptop/ tablet (e.g. iPad)															
6.Use remote controls (e.g. TV)															
					Total Score: Section A =									**Total Score: Section B =**	

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

11. MOVING AROUND OUTSIDE/ SHOPPING	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Walk on level ground															
2.Go for a long walk (e.g. a mile)															
3.Go up stairs without a handrail															
4.Travel by public transport															
5.Get in and out of a car and open car door															
6.Drive a car (e.g. hold steering wheel, turn car key, change gear)															
7.Fill the car with petrol															
8.Open a heavy (e.g. shop) door															
9.Walk around the shops															
10.Carry shopping															
11.Do the weekly shopping															
12.Hold a walking stick															
13.Use a mobility scooter															
Total Score: Section A =										**Total Score: Section B =**					

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

12. GARDENING / HOUSEHOLD MAINTENANCE	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Change a light bulb															
2.Light gardening (e.g. weed, prune, plant)															
3.Heavy gardening (e.g. dig, mow)															
4.Climb ladders															
5.Clean the car (inside and out)															
6.Do household repairs															
7.Car maintenance (eg oil, water)															
Total Score: Section A =										**Total Score: Section B =**					

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

13. CARING	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Feed a child, prepare bottles															
2.Bathe a child/ change nappies															
3.Dress a child															
4.Do a child's hair															
5.Use children's equipment (e.g. high chair, push chair, car seat)															
6.Put a child in/ out of high chair, push chair, high seat															
7.Lift and carry a child															
8.Play with children															
9.Care for others (e.g. elderly relatives)															
Total Score: Section A =										**Total Score: Section B =**					

Please tick (✓) to indicate your ability carrying out the activities listed below **during the last two weeks**. Please fill in **both** sections:
A: 'How do you do it **without** using an aid/gadget, alternate method or help?' If you do not normally do the activity, tick "not applicable".
B: 'How else do you do it **with** an aid/gadget or alternate method?" Fill in the middle columns. Leave B blank if you tick "no" or "have help."

14. HOBBIES, LEISURE & SOCIAL ACTIVITIES	**A.** How do you do it **without** an aid/ gadget, alternate method or help?						Do you use an aid or other method?		**Have help/ Some-one does it for me**	**B.** If yes, how else do you do it **with** an aid/gadget or alternate method?					
	Not Applicable	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score	**Yes**	**No**		Please describe below which **aid/s or other method/s** you use?	Without difficulty	Some difficulty	Much difficulty	Unable to do	Score
1.Crafts (e.g. knitting, crochet, sewing, embroidery, model making)															
2.Do-It-Yourself (e.g. using tools, decorating)															
3.Visit friends/ socialising (eg pub, cinema, theatre)															
4.Attend community / religious groups or classes															
5.Physical activities (e.g. dance, active sports, swimming, bicycling, fishing)															
6.Quiet recreation (e.g. painting, cards)															
7.Performing arts (e.g. music, choir, dramatics)															
8.Pet care (eg feed, groom)															
9.Take dog for a walk (e.g. hold leash)															
					Total Score: Section A =									**Total Score: Section B =**	

Finally:

1. Do you use / wear (*please tick if applicable*):

Wrist splint/s ☐ Walking aid ☐ Shoe insole/s ☐

Any other splint/s ☐ Please state: _____ Knee brace ☐

2. Overall, which aids/gadgets you own do you value the most?

_____

_____

3. How do you feel about using aids/gadgets? *(please circle the number)*

0 1 2 3 4 5 6 7 8 9 10

Not at all bothered Very bothered

4. What do you do yourself to help self-manage your symptoms/ condition?

_____

_____

_____

5. What is the most important thing you want to continue to do in life or to manage?

_____

_____

_____

If there is anything else you would like to tell us, or if you have any other comments, please write below:

Thank you for completing the EDAQ. Please check you have not missed any questions or pages.

Office Use only:

Name: _____ **Date: ___/___/____**

EDAQ Domain scores

	Domain	Section A Total Score	Section B Total Score	Difference: B-A
1	Eating/ Drinking			
2	In the Bathroom/ Personal Care			
3	Getting Dressed/ Undressed			
4	Bathing/ Showering			
5	Cooking			
6	Moving around Indoors			
7	Cleaning the House			
8	Laundry/ Clothes Care			
9	Moving & Transfers			
10	Communication			
11	Moving around Outdoors/ Shopping			
12	Gardening/ Household Maintenance			
13	Caring			
14	Hobbies, Leisure & Social Activities			
	SELF-CARE Score Domains: 1+2+3+5+7+8+10			
	MOBILITY/ PARTICIPATION Score Domains: 4+6+9+11+12			

(See EDAQ Manual v2 for scoring information).