

SARAH Trial



PARTICIPANTS ID:

# Strengthening And stretching for Rheumatoid Arthritis of the Hand (SARAH) Trial

## Baseline Participant Questionnaire

If you need to get in touch with the SARAH Trial research team, please contact:

SARAH Trial team  
Warwick Clinical Trials Unit



Phone: [REDACTED]  
Fax: [REDACTED]  
E-mail: [REDACTED]

**Please read these instructions before completing the questionnaire:**

Thank you for agreeing to take part in this study. The answers you give in this questionnaire will help us find out if the treatments you receive are helpful for your rheumatoid arthritis.

Please answer all the questions. Although it may seem that questions are asked more than once, it is still important that you answer every one.

Please follow the instructions for each section carefully.

**Crosses**

Some questions request that you place a cross in the box provided. If so, please use a cross rather than a tick, so that we can tell when you really meant to choose a particular box.

For example in the following question, if your answer 'yes', you should place a cross firmly in the box next to yes.

Do you drive a car?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
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**Circles**

Some questions request that you draw a small circle around a number that best represents your answer. If so, please use a circle rather than underlining a number, or placing a cross or a tick.

For example in the following question, if your answer is 'fair', you should draw a small circle around the number '3'.

How well did you drive today?	Very Good 1	Good 2	Fair <b>3</b>	Poor 4	Very Poor 5
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Please use a **BLACK or BLUE pen**. Please do not use a pencil.

Please check that you have completed all sections and return your completed questionnaire to the research clinician.

You will be asked to complete another questionnaire in approximately 4 months. Please keep a record of any days off work, and hospital or medical procedures you undergo as a result of your rheumatoid arthritis.

Please write any notes you have for the research team on the back page.

**Section 1**

This section is to find out some general information about you. Please answer the following questions as completely as you can.

1. What is the date you are completing this questionnaire?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

2. Approximately when were you first diagnosed with rheumatoid arthritis?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	Y	Y	Y	Y

3. Date of birth:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

4. Sex

	Male	Female
	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

5. What is your home postcode?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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6. To which of these ethnic groups do you consider you belong? (Please tick one box)

White	<input type="checkbox"/> <sub>1</sub>	Mixed	<input type="checkbox"/> <sub>2</sub>
Indian	<input type="checkbox"/> <sub>3</sub>	Pakistani	<input type="checkbox"/> <sub>4</sub>
Bangladeshi	<input type="checkbox"/> <sub>5</sub>	Black or Black British	<input type="checkbox"/> <sub>6</sub>
Chinese	<input type="checkbox"/> <sub>7</sub>	Other ethnic group	<input type="checkbox"/> <sub>8</sub>
Prefer not to say	<input type="checkbox"/> <sub>9</sub>		

7. What is your current marital status?

Single	<input type="checkbox"/> <sub>1</sub>	Married	<input type="checkbox"/> <sub>2</sub>
Separated	<input type="checkbox"/> <sub>3</sub>	Divorced	<input type="checkbox"/> <sub>4</sub>
Widowed	<input type="checkbox"/> <sub>5</sub>	Cohabiting	<input type="checkbox"/> <sub>6</sub>

8. Are you right-handed or left-handed?

Right	<input type="checkbox"/> <sub>1</sub>
Left	<input type="checkbox"/> <sub>2</sub>
Not clearly one or the other	<input type="checkbox"/> <sub>3</sub>

**Section 2**

This section asks for your views about your hands and your health. This information will provide information on how you feel and how well you are able to do your usual activities. Please answer every question by marking the answer that you judge to be most appropriate. If you are unsure about how to answer a question, please give the best answer you can.

**Section 2.1**

The following questions refer to the function of your hands/wrists **during the past week** (Please circle one answer for each question)

A. The following questions refer to your **right** hand/wrist.

	Very Good	Good	Fair	Poor	Very Poor
1. Overall, how well did your <b>right</b> hand work?	1	2	3	4	5
2. How well did your <b>right</b> fingers move?	1	2	3	4	5
3. How well did your <b>right</b> wrist move?	1	2	3	4	5
4. How was the strength in your <b>right</b> hand?	1	2	3	4	5
5. How was the sensation (feeling) in your <b>right</b> hand?	1	2	3	4	5

B. The following questions refer to your **left** hand/wrist.

	Very Good	Good	Fair	Poor	Very Poor
1. Overall, how well did your <b>left</b> hand work?	1	2	3	4	5
2. How well did your <b>left</b> fingers move?	1	2	3	4	5
3. How well did your <b>left</b> wrist move?	1	2	3	4	5
4. How was the strength in your <b>left</b> hand?	1	2	3	4	5
5. How was the sensation (feeling) in your <b>left</b> hand?	1	2	3	4	5

**Section 2.2**

The following questions refer to the ability of your hands to do certain tasks **during the past week**. If you have not performed a task during the past week, please estimate the difficulty that you would have had when performing it. (Please circle one answer for each question)

A. How difficult was it for you to perform the following activities using your **right hand**?

	Not at all difficult	A little difficult	Somewhat difficult	Moderately difficult	Very difficult
1. Turn a door knob?	1	2	3	4	5
2. Pick up a coin?	1	2	3	4	5
3. Hold a glass of water?	1	2	3	4	5
4. Turn a key in a lock?	1	2	3	4	5
5. Hold a frying pan?	1	2	3	4	5

B. How difficult was it for you to perform the following activities using your **left hand**?

	Not at all difficult	A little difficult	Somewhat difficult	Moderately difficult	Very difficult
1. Turn a door knob?	1	2	3	4	5
2. Pick up a coin?	1	2	3	4	5
3. Hold a glass of water?	1	2	3	4	5
4. Turn a key in a lock?	1	2	3	4	5
5. Hold a frying pan?	1	2	3	4	5

C. How difficult was it for you to perform the following activities using **both of your hands**?

	Not at all difficult	A little difficult	Somewhat difficult	Moderately difficult	Very difficult
1. Open a jar?	1	2	3	4	5
2. Button a shirt/blouse?	1	2	3	4	5
3. Eat with a knife/fork?	1	2	3	4	5
4. Carry a grocery bag?	1	2	3	4	5
5. Wash dishes?	1	2	3	4	5
6. Wash your hair?	1	2	3	4	5
7. Tie shoelaces/knots?	1	2	3	4	5

**Section 2.3**

The following questions refer to how you did in your normal work (including both housework and studying) **during the past 4 weeks**. (Please circle one answer for each question)

	Always	Often	Sometimes	Rarely	Never
1. How often were you unable to do your work because of problems with your hands/wrists?	1	2	3	4	5
2. How often did you have to shorten your work day because of problems with your hands/wrists?	1	2	3	4	5
3. How often did you have to take it easy at your work because of problems with your hands/wrists?	1	2	3	4	5
4. How often did you accomplish less in your work because of problems with your hands/wrists?	1	2	3	4	5
5. How often did you take longer to do the tasks in your work because of problems with your hands/wrists?	1	2	3	4	5

**Section 2.4**

The following questions refer to how much **pain** you had in your hands/wrists **during the past week**. (Please circle one answer for each question)

1. How often did you have pain in your hands/wrists?

- Always..... 1
- Often..... 2
- Sometimes..... 3
- Rarely..... 4
- Never..... 5

If you answered 'Never', please skip the following questions and go to **Section 2.5** on the next page.

2. Please describe the pain you have in your hands/wrists

- Very mild..... 1
- Mild..... 2
- Moderate..... 3
- Severe..... 4
- Very severe..... 5

	Always	Often	Sometimes	Rarely	Never
3. How often did the pain in your hands/wrists interfere with your sleep?	1	2	3	4	5
4. How often did the pain in your hands/wrists interfere with your daily activities (such as eating or bathing)?	1	2	3	4	5
5. How often did the pain in your hands/wrists make you unhappy?	1	2	3	4	5

**Section 2.5**

The following questions refer to the appearance (look) of your hands **during the past week**.  
 (Please circle one answer for each question)

A. The following questions refer to your **right** hand.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. I was satisfied with the appearance (look) of my <b>right</b> hand.	1	2	3	4	5
2. The appearance (look) of my <b>right</b> hand sometimes made me uncomfortable in public	1	2	3	4	5
3. The appearance (look) of my <b>right</b> hand made me depressed.	1	2	3	4	5
4. The appearance (look) of my <b>right</b> hand interfered with my normal social activities	1	2	3	4	5

B. The following questions refer to your **left** hand.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. I was satisfied with the appearance (look) of my <b>left</b> hand.	1	2	3	4	5
2. The appearance (look) of my <b>left</b> hand sometimes made me uncomfortable in public	1	2	3	4	5
3. The appearance (look) of my <b>left</b> hand made me depressed.	1	2	3	4	5
4. The appearance (look) of my <b>left</b> hand interfered with my normal social activities	1	2	3	4	5



**Section 2.6**

The following questions refer to your satisfaction with your hands/wrists **during the past week**.  
(Please circle one answer for each question)

A. The following questions refer to your **right** hand/wrist.

	Very satisfied	Somewhat satisfied	Neither satisfied nor dissatisfied	Somewhat dissatisfied	Very dissatisfied
1. Overall function of your <b>right</b> hand	1	2	3	4	5
2. Motion of the fingers in your <b>right</b> hand	1	2	3	4	5
3. Motion of your <b>right</b> wrist	1	2	3	4	5
4. Strength of your <b>right</b> hand	1	2	3	4	5
5. Pain level of your <b>right</b> hand	1	2	3	4	5
6. Sensation (feeling) of your <b>right</b> hand	1	2	3	4	5

B. The following questions refer to your **left** hand/wrist.

	Very satisfied	Somewhat satisfied	Neither satisfied nor dissatisfied	Somewhat dissatisfied	Very dissatisfied
1. Overall function of your <b>left</b> hand	1	2	3	4	5
2. Motion of the fingers in your <b>left</b> hand	1	2	3	4	5
3. Motion of your <b>left</b> wrist	1	2	3	4	5
4. Strength of your <b>left</b> hand	1	2	3	4	5
5. Pain level of your <b>left</b> hand	1	2	3	4	5
6. Sensation (feeling) of your <b>left</b> hand	1	2	3	4	5

**Section 3**

During the past week, how troublesome has your pain been in the following areas?

(please provide an answer for both hands and wrists)

	No pain experienced	Not at all troublesome	Slightly troublesome	Moderately troublesome	Very troublesome	Extremely troublesome
1. Right hand	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
2. Left hand	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
3. Right wrist	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
4. Left wrist	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>

**Section 4**

The following questions refer to how confident you feel in performing certain tasks.  
(Please circle one answer for each question)

1. How confident are you that you can do all the things necessary for you to manage your condition on a regular basis?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>
2. How confident are you that you can judge when the changes in your condition mean you should visit a doctor?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>
3. How confident are you that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>
4. How confident are you that you can reduce the emotional distress caused by your health condition so that it does not affect your everyday life?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>
5. How confident are you that you can do things other than just taking medication to reduce how much your illness affects your everyday life?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>
6. How confident are you that you can do gentle exercises for muscle strength and flexibility three to four times per week?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>
7. How confident are you that you can exercise without making your symptoms worse?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>



PARTICIPANTS ID:

# Strengthening And stretching for Rheumatoid Arthritis of the Hand (SARAH) Trial

## Baseline

## Research Clinic Assessment Form

If you need to get in touch with the SARAH Trial research team, please contact:

SARAH Trial team  
Warwick Clinical Trials Unit



Phone: [REDACTED]  
Fax: [REDACTED]  
E-mail: [REDACTED]

**Section 1**

This section is to ensure the research team have sufficient details about the assessment that you are performing. **Please ensure that you have entered the participant's ID number on the front cover of this assessment form.**

1. Date you are completing this assessment:

D	D	M	M	Y	Y	Y	Y

2. Time that you began completing this assessment (24 hour clock):

H	H	M	M

3. Centre ID:

--	--	--	--	--	--	--	--

4. Research clinician's name:

--	--	--	--	--	--	--	--

**Section 2**

This section relates to information about the participant provided from blood tests **that you will need to collect from their medical records.**

1. Latest CRP level (mg/l):

--	--	--

2. Date latest CRP was measured:

D	D	M	M	Y	Y	Y	Y

3. Latest ESR level (mm/hour):

--	--	--

4. Date latest ESR was measured:

D	D	M	M	Y	Y	Y	Y

5. Rheumatoid factor:

Positive	Negative
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

Not available	
<input type="checkbox"/> <sub>3</sub>	

**Section 3**

This section relates to the medication that the participant is taking. **This information can be provided by the participant or you may need to collect it from their medical records.**

3. Prescribed current medications:			
Drug	Yes	Dose	How often
Ibuprofen	<input type="checkbox"/> <sub>1</sub>		
Naproxen	<input type="checkbox"/> <sub>2</sub>		
Diclofenac	<input type="checkbox"/> <sub>3</sub>		
Indomethacin	<input type="checkbox"/> <sub>4</sub>		
Other non-steroidal anti-inflammatory	<input type="checkbox"/> <sub>5</sub>		
Sulfasalazine	<input type="checkbox"/> <sub>6</sub>		
Hydroxychloroquine	<input type="checkbox"/> <sub>7</sub>		
Methotrexate	<input type="checkbox"/> <sub>8</sub>		
Gold injections	<input type="checkbox"/> <sub>9</sub>		
Leflunomide	<input type="checkbox"/> <sub>10</sub>		
Azathioprine	<input type="checkbox"/> <sub>11</sub>		
Prednisolone	<input type="checkbox"/> <sub>12</sub>		
Infliximab [Remicade]	<input type="checkbox"/> <sub>13</sub>		
Etanercept [Enbrel]	<input type="checkbox"/> <sub>14</sub>		
Adalimumab [Humira]	<input type="checkbox"/> <sub>15</sub>		
Other:	<input type="checkbox"/> <sub>16</sub>		

4. Any additional 'as required' medications (only those used in last 7 days):	
Drug	Yes
Extra non-steroidal anti-inflammatory	<input type="checkbox"/> <sub>1</sub>
Steroid tablet	<input type="checkbox"/> <sub>2</sub>
Steroid injection into joint	<input type="checkbox"/> <sub>3</sub>
Steroid injection into muscle	<input type="checkbox"/> <sub>4</sub>

**Section 4**

**Measuring Metacarpophalangeal (MCP) Joint Deformity**

Participants should be advised to sit comfortably in a chair, with their forearms and hands supported on a table in front in a pronated position (palm facing down). All potentially interfering jewellery should be removed.

When measuring MCP joint deformity, a goniometer is placed on the back of the hand. The centre of the goniometer is placed over the MCP joint, with one arm placed along the midline of the finger (centred over the PIP joint), and the other arm placed along the associated metacarpal, lining the 180 degree marker up with the midline of the finger (see figure below). This process should be repeated for all four fingers on each hand.

**NB:** Ulnar deviation (fingers bent away from thumb) is recorded as a positive value.  
 Radial deviation (fingers bent towards the thumb) is recorded as a negative value.

In this example, all values would be recorded as positive as all the fingers bend away from the thumb.



Figure 4.1. Measuring MCP joint deformity



MCP Joint Deformity (degrees)

	Left hand	Right hand
Index finger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Middle finger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Ring finger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Little finger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

## Section 5

### Measuring Active Wrist Flexion

Participants should be advised to sit comfortably in a chair with their elbow supported on a table in front of them and all potentially interfering jewellery removed.

The elbow is bent to approximately 90 degrees and the wrist should be in a neutral position (palm neither facing up nor down, similar to an 'arm wrestling' position).

When measuring wrist flexion, a goniometer is placed on the back of the forearm and the hand in line with the midline of the forearm and the metacarpal/phalanx of the middle (3<sup>rd</sup>) finger.

Participants are instructed to "bend your wrist down as far as you can go with your fingers in a relaxed position" and then the measurement should be recorded.

Figure 5.1. Measuring wrist flexion



Active wrist flexion (degrees)

	Left wrist	Right wrist
Wrist flexion	<input type="text"/>	<input type="text"/>



**Section 5 (continued)**

**Measuring Active Wrist Extension**

When measuring wrist extension, a goniometer is placed on the palmar side of the forearm and the hand (as shown in Figure 5.2), in line with the midline of the forearm and the middle (3<sup>rd</sup>) metacarpal/phalanx .

Participants are instructed to “bend your wrist back as far as you can go with your fingers in a relaxed position” and then the measurement should be recorded.

Figure 5.2. Measuring wrist extension



Active wrist extension (degrees)

		Left wrist		Right wrist	
Wrist extension		<input type="text"/>		<input type="text"/>	

**Section 5 (continued)**

**Measuring Combined Finger Flexion**

Combined Finger Flexion is a measurement from each distal corner of the nail bed on the radial border (thumb side) to the distal palmar crease of the palm.

To perform a measurement, the elbow is bent to approximately 45 degrees and the wrist should be in a neutral position (palm neither facing up nor down).

Participants are instructed to “make a fist as much as you can” and then the ruler on the end of the goniometer is used to measure the distance between the tip of the distal corner of the nail bed on the radial border (thumb side) to the distal palmar crease of the palm.

Figure 5.3. Measuring Composite Finger Flexion



Combined Finger Flexion (mm)

	Left hand	Right hand
Index finger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Middle finger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Ring finger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Little finger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

**Section 5 (continued)**

**Method A - Measuring Composite Finger Extension**

For composite finger extension, the elbow is bent to approximately 45 degrees and palm should be facing down (wrist pronated) to rest flat on the table.

**If the patient is unable to achieve this position (they have flexion deformities) please use the next page**

Participants are instructed to “lift your finger up towards the ceiling as much as you can” and then the ruler on the end of the goniometer is used to measure the distance between the tip of the distal corner of the nail bed on the radial border (thumb side) to the table top. This process is repeated for all the fingers (not the thumb).

**NB:** if the amount of extension is greater than what can be recorded by the ruler, mark the distance on a sheet of paper and then use the ruler to measure this afterwards.

Figure 5.4a. Measuring Composite Finger Extension



Combined Finger Extension (mm)

		Left hand	Right hand
Index finger		<input type="text"/>	<input type="text"/>
Middle finger		<input type="text"/>	<input type="text"/>
Ring finger		<input type="text"/>	<input type="text"/>
Little finger		<input type="text"/>	<input type="text"/>

**Section 5 (continued)**

**Method B - Measuring Composite Finger Extension with patients who have finger flexion deformities .**

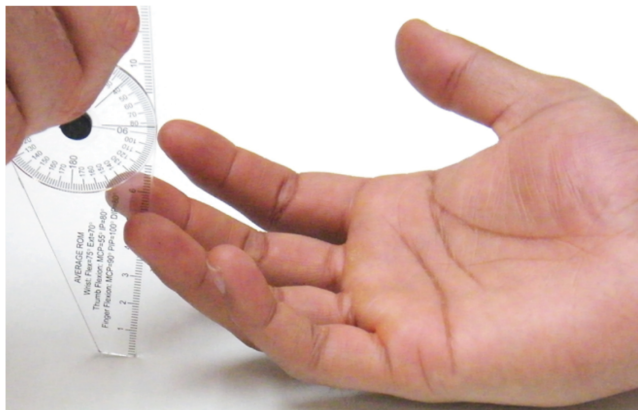
**\* Only use this page if you were unable to complete the previous page \***

For composite finger extension, the elbow is bent to approximately 45 degrees and palm should be facing up (wrist supinated).

Participants are instructed to “try and straighten your fingers towards the table as much as you can” and then the ruler on the end of the goniometer is used to measure the distance between the tip of the distal corner of the nail bed on the radial border (thumb side) to the table top. This process is repeated for all the fingers (not the thumb).

**NB:** if the amount of extension is greater than what can be recorded by the ruler, mark the distance on a sheet of paper and then use the ruler to measure this afterwards.

Figure 5.4b. Measuring Composite Finger Extension for finger flexion deformities



Combined Finger Extension (mm)

	Left hand	Right hand
Index finger	<input type="text"/>	<input type="text"/>
Middle finger	<input type="text"/>	<input type="text"/>
Ring finger	<input type="text"/>	<input type="text"/>
Little finger	<input type="text"/>	<input type="text"/>

**Section 5 (continued)**

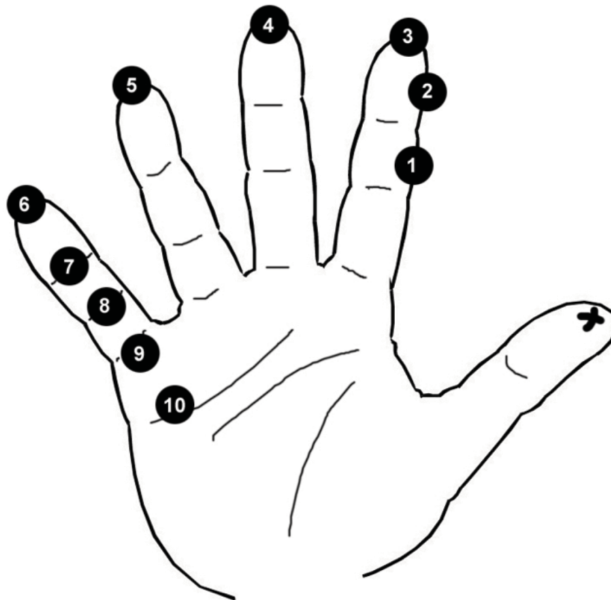
**Thumb Opposition**

The Kapandji test of thumb opposition has been chosen as it offers a simple system of using the hand as a system of reference<sup>30</sup>. The patient is asked to do the following movements with the tip of the thumb (see 'x' on Figure below) :

1. Touch the lateral side of the second phalanx of the index finger
2. Touch the lateral side of the third phalanx of the index finger
3. Touch the tip of the index finger
4. Touch the tip of the middle finger
5. Touch the tip of the ring finger
6. Touch the tip of the little finger
7. Touch the palmar DIP crease of the little finger
8. Touch the palmar PIP crease of the little finger
9. Touch the proximal palmar crease of the little finger
10. Touch the distal palmar crease of the hand

The score is the highest number that the participant can achieve (maximum =10).

Figure 5.5. The 10 points of the Kapandji test of thumb opposition



**Thumb Opposition Score (1-10)**

	Left Thumb		Right Thumb	
Score	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Section 6**

**Swollen & Tender joint count**

Joint swelling is defined as soft tissue swelling that is detectable along the joint margins. Neither bony enlargement nor deformity of the joint constitutes swelling. Each swollen joint should be marked on the diagram below, and the total count should be written in the adjoining boxes.

Joint tenderness is defined as pain at rest that is induced by pressure. The examiner uses his/her thumb and index finger to exert pressure that is sufficient to cause 'whitening' of the examiner's nail beds. Each tender joint should be marked on the diagram below, and the total count should be written in the adjoining boxes.

**Procedure**

Participants should be advised to sit comfortably in a chair, with their forearms and hands supported on a table in front in a pronated position (palm facing down). All potentially interfering jewellery should be removed.

PIP/MCP joints

Examine each joint in turn starting with the PIP joints. Examine right and left anterior joint margins using both thumbs while the fingers are supporting the patient's hand. Repeat process on dorsal and palmar joint margins.

Wrist joint

Using the same procedure as above, examine the wrist in the neutral position. Use both hands to examine with thumbs on the dorsal surface and fingers on palmar surface of the patient's wrist.



Please mark each swollen and tender joint on the diagrams below and write the total joint counts in the adjoining boxes.

Swollen Joints	Tender Joints
<input type="text"/> <input type="text"/> / 22	<input type="text"/> <input type="text"/> / 22

## **Section 7**

### **Timed upper limb dexterity**

#### 1. The Nine-hole peg test—instructions

The test involves the subject placing 9 dowels in 9 holes, and then removing them. Participants are scored by the amount of time it takes to do this.

For this test you will require:

- A pen
- Nine Hole Peg Test (board and pegs)
- Plastic bowl
- Digital stopwatch

The participant should be:

- Sitting at a desk in a straight-backed chair (without armrests) with their feet flat on the floor.
- The pegboard should be centred in front of the subject.
- A shallow round bowl (or similar container) containing the nine pegs should be placed on the same side as the hand being tested.

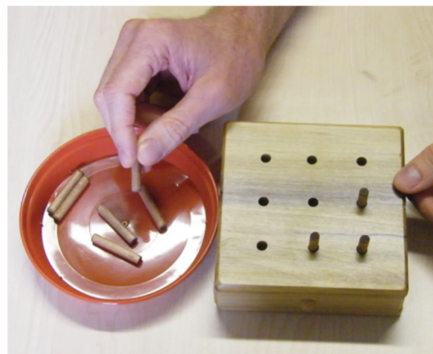
The following instructions should be given to the participant as you briefly demonstrate the test:

“Pick up the pegs one at a time, using your right (or left) hand only and put them into the holes in any order until all the holes are filled. Then remove the pegs one at a time and return them to the container. Stabilise the peg board with your left (or right) hand. This is a practice test. See how fast you can put all the pegs in and take them out again. Are you ready? Go!”

- After the subject completes the practice trial, you say:

“This will be the actual test. The instructions are the same. Work as quickly as you can. Are you ready? Go! [During the test] Fast as you can. [As soon as the last peg is in the board] Out again...as fast as you can.”

- The stopwatch should be started as soon as the subject touched the first peg and stopped when the last peg hit the container.
- The container is then placed on the opposite side of the pegboard. The test is then repeated in the same way for the non-dominant hand.



The Nine-hole peg test—measurements (minutes and seconds)

	M	S	S	s	s		
Right upper limb	<input type="text"/>	:	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>
Left upper limb	<input type="text"/>	:	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>

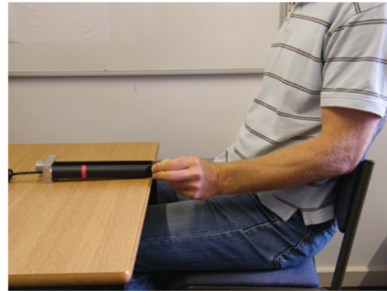


## **Section 8**

### **Full-hand and pinch grip strength—instructions**

#### **Test Position:**

Sitting in a straight-backed chair (without armrests) with feet flat on the floor the participant should be positioned as in the pictures below. Refer to p34 of the manual for full details.



#### **Remember:**

1. For the measurement of full-hand grip, the red band should be positioned closest to the examiner
2. For the measurement of tripod pinch grip, the red band should be positioned on the side of the index and middle finger.
3. Make sure the measuring device is the correct width for the participant and record this on the form.
4. You need to reset the machine before every test. You do this by pushing the “zero” button with the measuring device flat on the table.
5. Ensure the ‘hold’ button remains depressed throughout all tests.

#### **Verbal instructions for each test:**

“When I say “go” I want you to squeeze as hard as you can, and as quickly as you can and hold it for 3 seconds. Go! 1, 2, 3. Stop.”

#### **Order of testing:**

Practice *full-hand* grip with each hand

Dominant hand maximum *full-hand* grip (3 seconds)

30 seconds rest

Non-dominant hand maximum *full-hand* grip (3 seconds)

30 seconds rest

Repeat 3 times in total

Practice *pinch* grip with each hand

Dominant hand maximum *pinch* grip (3 seconds)

30 second rest

Non-dominant hand maximum *pinch* grip (3 seconds)

30 seconds rest

Repeat 3 times in total

**Section 8 (continued)**

**Full-hand and pinch grip strength—measurements**

1. Maximum full-hand grip force (Newtons)

Full grip	Left hand			Right hand		
1st trial						
2nd trial						
3rd trial						

Grip Handle Width used using inside edges (mm):

--	--

2. Maximum 'tripod' pinch grip force (Newtons)

Pinch grip	Left hand			Right hand		
1st trial						
2nd trial						
3rd trial						

**Use the same Grip Handle Width as full-hand grip test**

Please check that all sections have been completed .

**Please ensure that you have entered the participant's ID number on the front cover of this questionnaire.**

Please write any notes you have for the SARAH trial team in the space below.

Thank you very much for your time.



STRENGTHENING AND STRETCHING FOR RHEUMATOID ARTHRITIS OF THE HAND

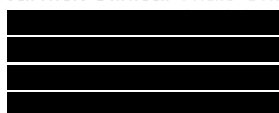
PARTICIPANTS ID:

# Strengthening And stretching for Rheumatoid Arthritis of the Hand (SARAH) Trial

## Participant 12 month Follow-up Questionnaire

If you need to get in touch with the SARAH Trial research team, please contact:

SARAH Trial team  
Warwick Clinical Trials Unit



Phone: [REDACTED]

Fax: [REDACTED]

E-mail: [REDACTED]

**Please read these instructions before completing the questionnaire:**

Thank you for agreeing to take part in this study. The answers you give in this questionnaire will help us find out if the treatments you get are helpful for your rheumatoid arthritis.

Please answer all the questions. Although it may seem that questions are asked more than once, it is still important that you answer every one.

Please follow the instructions for each section carefully.

**Crosses**

Some questions request that you place a cross in the box provided. If so, please use a cross rather than a tick.

For example in the following question, if you answer 'yes', you should place a cross firmly in the box next to yes.

Do you drive a car?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
---------------------	--	--------------------------------

**Circles**

Some questions request that you draw a small circle around a number that best represents your answer. If so, please use a circle rather than underlining a number, or placing a cross or a tick.

For example in the following question, if your answer is 'fair', you should draw a small circle around the number 3.

How well did you drive today?	Very Good 1	Good 2	Fair <b>3</b>	Poor 4	Very Poor 5
-------------------------------	----------------	-----------	------------------	-----------	----------------

Please use a **BLACK or BLUE pen**. Please do not use a pencil.

Please check that you have completed all sections and return your completed questionnaire to the research clinician.

Please write any notes you have for the research team on the back page.

What is the date you are completing this questionnaire?

D	D	M	M	Y	Y	Y	Y

**Section 1**

This section asks for your views about your hands and your health. This information will provide information on how you feel and how well you are able to do your usual activities. Please answer every question by marking the answer that you judge to be most appropriate. If you are unsure about how to answer a question, please give the best answer you can.

**Section 1.1**

The following questions refer to the function of your hands/wrists **during the past week** (Please circle one answer for each question)

A. The following questions refer to your **right** hand/wrist.

	Very Good	Good	Fair	Poor	Very Poor
1. Overall, how well did your <b>right</b> hand work?	1	2	3	4	5
2. How well did your <b>right</b> fingers move?	1	2	3	4	5
3. How well did your <b>right</b> wrist move?	1	2	3	4	5
4. How was the strength in your <b>right</b> hand?	1	2	3	4	5
5. How was the sensation (feeling) in your <b>right</b> hand?	1	2	3	4	5

B. The following questions refer to your **left** hand/wrist.

	Very Good	Good	Fair	Poor	Very Poor
1. Overall, how well did your <b>left</b> hand work?	1	2	3	4	5
2. How well did your <b>left</b> fingers move?	1	2	3	4	5
3. How well did your <b>left</b> wrist move?	1	2	3	4	5
4. How was the strength in your <b>left</b> hand?	1	2	3	4	5
5. How was the sensation (feeling) in your <b>left</b> hand?	1	2	3	4	5

**Section 1.2**

The following questions refer to the ability of your hands to do certain tasks **during the past week**. If you have not performed a task during the past week, please estimate the difficulty that you would have had when performing it. (Please circle one answer for each question)

A. How difficult was it for you to perform the following activities using your **right hand**?

	Not at all difficult	A little difficult	Somewhat difficult	Moderately difficult	Very difficult
1. Turn a door knob?	1	2	3	4	5
2. Pick up a coin?	1	2	3	4	5
3. Hold a glass of water?	1	2	3	4	5
4. Turn a key in a lock?	1	2	3	4	5
5. Hold a frying pan?	1	2	3	4	5

B. How difficult was it for you to perform the following activities using your **left hand**?

	Not at all difficult	A little difficult	Somewhat difficult	Moderately difficult	Very difficult
1. Turn a door knob?	1	2	3	4	5
2. Pick up a coin?	1	2	3	4	5
3. Hold a glass of water?	1	2	3	4	5
4. Turn a key in a lock?	1	2	3	4	5
5. Hold a frying pan?	1	2	3	4	5

C. How difficult was it for you to perform the following activities using **both of your hands**?

	Not at all difficult	A little difficult	Somewhat difficult	Moderately difficult	Very difficult
1. Open a jar?	1	2	3	4	5
2. Button a shirt/blouse?	1	2	3	4	5
3. Eat with a knife/fork?	1	2	3	4	5
4. Carry a grocery bag?	1	2	3	4	5
5. Wash dishes?	1	2	3	4	5
6. Wash your hair?	1	2	3	4	5
7. Tie shoelaces/knots?	1	2	3	4	5

**Section 1.3**

The following questions refer to how you did in your normal work (including both housework and studying) **during the past 4 weeks**. (Please circle one answer for each question)

	Always	Often	Sometimes	Rarely	Never
1. How often were you unable to do your work because of problems with your hands/wrists?	1	2	3	4	5
2. How often did you have to shorten your work day because of problems with your hands/wrists?	1	2	3	4	5
3. How often did you have to take it easy at your work because of problems with your hands/wrists?	1	2	3	4	5
4. How often did you accomplish less in your work because of problems with your hands/wrists?	1	2	3	4	5
5. How often did you take longer to do the tasks in your work because of problems with your hands/wrists?	1	2	3	4	5



**Section 1.4**

The following questions refer to how much **pain** you had in your hands/wrists **during the past week**. (Please circle one answer for each question)

1. How often did you have pain in your hands/wrists?

- Always..... 1
- Often..... 2
- Sometimes..... 3
- Rarely..... 4
- Never..... 5

If you answered 'Never', please skip the following questions and go to **Section 1.5** on the next page.

2. Please describe the pain you have in your hands/wrists

- Very mild..... 1
- Mild..... 2
- Moderate..... 3
- Severe..... 4
- Very severe..... 5

	Always	Often	Sometimes	Rarely	Never
3. How often did the pain in your hands/wrists interfere with your sleep?	1	2	3	4	5
4. How often did the pain in your hands/wrists interfere with your daily activities (such as eating or bathing)?	1	2	3	4	5
5. How often did the pain in your hands/wrists make you unhappy?	1	2	3	4	5

**Section 1.5**

The following questions refer to the appearance (look) of your hands **during the past week**.  
 (Please circle one answer for each question)

A. The following questions refer to your **right** hand.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. I was satisfied with the appearance (look) of my <b>right</b> hand.	1	2	3	4	5
2. The appearance (look) of my <b>right</b> hand sometimes made me uncomfortable in public	1	2	3	4	5
3. The appearance (look) of my <b>right</b> hand made me depressed.	1	2	3	4	5
4. The appearance (look) of my <b>right</b> hand interfered with my normal social activities	1	2	3	4	5

B. The following questions refer to your **left** hand.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. I was satisfied with the appearance (look) of my <b>left</b> hand.	1	2	3	4	5
2. The appearance (look) of my <b>left</b> hand sometimes made me uncomfortable in public	1	2	3	4	5
3. The appearance (look) of my <b>left</b> hand made me depressed.	1	2	3	4	5
4. The appearance (look) of my <b>left</b> hand interfered with my normal social activities	1	2	3	4	5

**Section 1.6**

The following questions refer to your satisfaction with your hands/wrists **during the past week**.  
(Please circle one answer for each question)

A. The following questions refer to your **right** hand/wrist.

	Very satisfied	Somewhat satisfied	Neither satisfied nor dissatisfied	Somewhat dissatisfied	Very dissatisfied
1. Overall function of your <b>right</b> hand	1	2	3	4	5
2. Motion of the fingers in your <b>right</b> hand	1	2	3	4	5
3. Motion of your <b>right</b> wrist	1	2	3	4	5
4. Strength of your <b>right</b> hand	1	2	3	4	5
5. Pain level of your <b>right</b> hand	1	2	3	4	5
6. Sensation (feeling) of your <b>right</b> hand	1	2	3	4	5

B. The following questions refer to your **left** hand/wrist.

	Very satisfied	Somewhat satisfied	Neither satisfied nor dissatisfied	Somewhat dissatisfied	Very dissatisfied
1. Overall function of your <b>left</b> hand	1	2	3	4	5
2. Motion of the fingers in your <b>left</b> hand	1	2	3	4	5
3. Motion of your <b>left</b> wrist	1	2	3	4	5
4. Strength of your <b>left</b> hand	1	2	3	4	5
5. Pain level of your <b>left</b> hand	1	2	3	4	5
6. Sensation (feeling) of your <b>left</b> hand	1	2	3	4	5

**Section 2**

During the past week, how troublesome has your pain been in the following areas?

(please provide an answer for both hands and wrists)

	No pain experienced	Not at all troublesome	Slightly troublesome	Moderately troublesome	Very troublesome	Extremely troublesome
1. Right hand	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
2. Left hand	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
3. Right wrist	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>
4. Left wrist	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>

**Section 3**

1. In what way has your arthritis in your hands and/or wrists changed in the past four months?

(Please place a cross in one box)

- Completely recovered..... <sub>1</sub>
- Much improved..... <sub>2</sub>
- Slightly improved..... <sub>3</sub>
- No change..... <sub>4</sub>
- Slightly worsened..... <sub>5</sub>
- Much worsened..... <sub>6</sub>
- Vastly worsened..... <sub>7</sub>

**Section 4**

The following questions refer to how confident you feel in performing certain tasks.  
 (Please circle one answer for each question)

1. How confident are you that you can do all the things necessary for you to manage your condition on a regular basis?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>
2. How confident are you that you can judge when the changes in your condition mean you should visit a doctor?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>
3. How confident are you that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>
4. How confident are you that you can reduce the emotional distress caused by your health condition so that it does not affect your everyday life?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>
5. How confident are you that you can do things other than just taking medication to reduce how much your illness affects your everyday life?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>
6. How confident are you that you can do gentle exercises for muscle strength and flexibility three to four times per week?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>
7. How confident are you that you can exercise without making your symptoms worse?											
<b>Not at all confident</b>	1	2	3	4	5	6	7	8	9	10	<b>Totally confident</b>

**Section 5**

The following questions refer to the treatment you have received as part of the SARAH Trial.  
 (Please circle one answer for each question)

How often was each of the following statements true for you during the past 4 weeks?

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
1. I had a hard time doing what the therapist suggested I do	1	2	3	4	5	6
2. I followed the therapist's suggestions exactly	1	2	3	4	5	6
3. I was unable to do what was necessary to follow the therapist's treatment plans	1	2	3	4	5	6
4. I found it easy to do the things the therapist suggested I do	1	2	3	4	5	6
5. Generally speaking, I was able to do what I was told by the therapist	1	2	3	4	5	6

6. How much benefit have you gained from the advice or treatment you have received as part of the SARAH Trial?

- Substantial benefit ..... 1
- Moderate benefit ..... 2
- No benefit ..... 3
- Moderate harm ..... 4
- Substantial harm ..... 5

7. How satisfied were you with the advice or treatment that you received as part of the SARAH Trial?

- Extremely dissatisfied ..... 1
- Very dissatisfied ..... 2
- Somewhat dissatisfied ..... 3
- Neither satisfied nor dissatisfied ..... 4
- Somewhat satisfied ..... 5
- Very satisfied ..... 6
- Extremely satisfied ..... 7

**Section 5 cont'd**

8. Are you currently doing any hand or wrist exercises to help with your arthritis? *(please circle)*

No

Yes .....▶ go to question 9

9. If **yes**, how often are you doing these exercises? *(please circle)*

Daily

3-4 times a week

1-2 times a week

Other: .....

**Section 6** - The following questions are to ask about your general health state **at the moment**. By placing a cross in one box in each group below, please indicate which statement best describes your own health state **today**.

Please place a cross within **one** box for each question

1. Mobility	
I have no problems in walking about	<input type="checkbox"/> <sub>1</sub>
I have some problems in walking about	<input type="checkbox"/> <sub>2</sub>
I am confined to bed	<input type="checkbox"/> <sub>3</sub>
2. Self Care	
I have no problems with self-care	<input type="checkbox"/> <sub>1</sub>
I have some problems washing or dressing myself	<input type="checkbox"/> <sub>2</sub>
I am unable to wash or dress myself	<input type="checkbox"/> <sub>3</sub>
3. Usual Activities (e.g. work, study, housework, family or leisure activities)?	
I have no problems with performing my usual activities	<input type="checkbox"/> <sub>1</sub>
I have some problems with performing my usual activities	<input type="checkbox"/> <sub>2</sub>
I am unable to perform my usual activities	<input type="checkbox"/> <sub>3</sub>
4. Pain / Discomfort	
I have no pain or discomfort	<input type="checkbox"/> <sub>1</sub>
I have moderate pain or discomfort	<input type="checkbox"/> <sub>2</sub>
I have extreme pain or discomfort	<input type="checkbox"/> <sub>3</sub>
5. Anxiety / Depression	
I am not anxious or depressed	<input type="checkbox"/> <sub>1</sub>
I am moderately anxious or depressed	<input type="checkbox"/> <sub>2</sub>
I am extremely anxious or depressed	<input type="checkbox"/> <sub>3</sub>



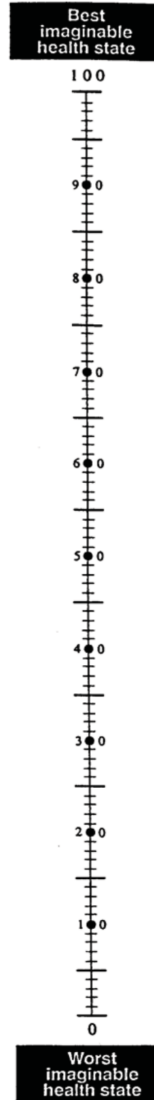
## Your own health state today

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked by 100 and the worst state you can imagine is marked by 0.

We would like you to indicate on this scale **how good or bad is your own health today**, in your opinion.

Please do this by drawing a line from the box below, to whichever point on the scale indicates how good or bad your current health state is today.

Your own health state  
TODAY



**Section 7**

This section asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. For each of the following questions please place a cross in the one box that best describes your answer.

1. In general, would you say your health is:				
Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

2. The following questions are about activities you might do during a typical day.			
Does <b>your health now</b> limit you in these activities? If so, how much?			
	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. <b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling or playing golf	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
b. Climbing <b>several</b> flights of stairs	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

3. During the <b>past 4 weeks</b> , how much of the time have you had any of the following problems with your work or other regular daily activities <b>as a result of your physical health</b> ?					
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. <b>Accomplished less</b> than you would like	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
b. Were limited in the kind of work or other activities	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

4. During the <b>past 4 weeks</b> , how much of the time have you had any of the following problems with your work or other regular daily activities <b>as a result of any emotional problems</b> (such as feeling depressed or anxious)?					
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. <b>Accomplished less</b> than you would like	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
b. Were limited in the kind of work or other activities	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**Section 7 cont'd**

5. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

Not at all <input type="checkbox"/> <sub>1</sub>	A little bit <input type="checkbox"/> <sub>2</sub>	Moderately <input type="checkbox"/> <sub>3</sub>	Quite a bit <input type="checkbox"/> <sub>4</sub>	Extremely <input type="checkbox"/> <sub>5</sub>
---	---	---	--	--

6. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

**How much of the time during the past 4 weeks:**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
b. Did you have a lot of energy?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
c. Have you felt downhearted and low?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

7. During the **past 4 weeks**, how much of the time have your **physical health OR emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time <input type="checkbox"/> <sub>1</sub>	Most of the time <input type="checkbox"/> <sub>2</sub>	Some of the time <input type="checkbox"/> <sub>3</sub>	A little of the time <input type="checkbox"/> <sub>4</sub>	None of the time <input type="checkbox"/> <sub>5</sub>
--	---	---	---	---

**Section 8**

This section asks about your current work status and income. This is because we want to ensure that this research reaches everybody who is entitled to treatment, including people of all backgrounds, income and status. Furthermore, loss of income has an impact on society as a whole and it is therefore important that we attempt to measure this.

<b>1. During the past 4 months, have you had to take any days off work as sick leave because of rheumatoid arthritis?</b>			
Yes	No	Not Applicable	
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	
If <b>yes</b> , how many days did you have to take off work as sick leave?			<input type="text"/> <input type="text"/>

<b>2. Has your benefit status changed in the past 4 months?</b>		Yes	No
		<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
If <b>yes</b> , please insert a cross next to all benefits that you are receiving?			
Housing and Homeless Assistance	<input type="checkbox"/> <sub>1</sub>	Attendance Allowance	<input type="checkbox"/> <sub>2</sub>
Severe Disablement Allowance	<input type="checkbox"/> <sub>3</sub>	Carer's Allowance	<input type="checkbox"/> <sub>4</sub>
Disability Living Allowance	<input type="checkbox"/> <sub>5</sub>	Income Support	<input type="checkbox"/> <sub>6</sub>
Working Tax Credit	<input type="checkbox"/> <sub>7</sub>	Social Fund Payment	<input type="checkbox"/> <sub>8</sub>
Council Tax Benefit	<input type="checkbox"/> <sub>9</sub>	Child Benefit	<input type="checkbox"/> <sub>10</sub>
Income based Jobseekers' Allowance	<input type="checkbox"/> <sub>11</sub>	Housing Benefits	<input type="checkbox"/> <sub>12</sub>
Pension Credit	<input type="checkbox"/> <sub>13</sub>	Child Tax Credit	<input type="checkbox"/> <sub>14</sub>
Other (please specify)	<input type="checkbox"/> <sub>15</sub>	_____	

**Section 9**

**This section is about health care you have received because of rheumatoid arthritis during the last 4 months.**

Please read each question carefully. For each question, if you have had no treatments or visits, please enter '0'.

**NHS health care: this section is about any treatment you have received on the NHS only**

1. During the past 4 months, how often have you used any of the following **NHS services** because of rheumatoid arthritis?

Please do not include any sessions or treatments that you attended as part of the SARAH Trial.

	Number of times		
Your GP or another GP	<input type="text"/>	<input type="text"/>	If none enter '0'
Rheumatologist (consultant or a doctor from their team)	<input type="text"/>	<input type="text"/>	If none enter '0'
Orthopaedic surgeon (consultant or a doctor from their team)	<input type="text"/>	<input type="text"/>	If none enter '0'
Other hospital specialist (consultant or a doctor from their team)	<input type="text"/>	<input type="text"/>	If none enter '0'
Nurse	<input type="text"/>	<input type="text"/>	If none enter '0'
Physiotherapist	<input type="text"/>	<input type="text"/>	If none enter '0'
Occupational therapist	<input type="text"/>	<input type="text"/>	If none enter '0'
Podiatrist / Chiropodist	<input type="text"/>	<input type="text"/>	If none enter '0'
Self-management group eg Expert Patient Programme	<input type="text"/>	<input type="text"/>	If none enter '0'
Other NHS service (please specify) _____	<input type="text"/>	<input type="text"/>	If none enter '0'

2. During the past 4 months, have you spent one or more nights in an **NHS hospital** because of rheumatoid arthritis?

Yes	No
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

If **yes**, what was the total number of nights that you spent in hospital ? \_\_\_\_\_ nights

Was this hospital admission for surgery ?

Yes	No
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

If **yes**, a) in which hospital was the surgery performed? \_\_\_\_\_

b) What was the operation performed? \_\_\_\_\_

If **no**, please state reason for admission \_\_\_\_\_

3. <b>During the past 4 months</b> , have you spent <u>one or more nights</u> in an <b>NHS hospital</b> for any other reason (apart from rheumatoid arthritis)?	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2
If <b>yes</b> , what was the total <u>number of nights</u> that you spent in hospital ?	_____ nights	
Please state reason for admission _____		

4. <b>During the past 4 months</b> , have you attended an <b>NHS hospital</b> as a 'day case' patient (you were admitted to the hospital for tests or treatment but you did not stay overnight) <b>because of rheumatoid arthritis</b> ?	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2
If <b>yes</b> , a) how many times did you attend ?	_____ times	
b) Were these 'day case' attendances for receiving medication ?	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2
(i) If <b>yes</b> , what medication did you receive? _____		
(ii) If <b>no</b> , please state reason _____		
c) which hospital did you attend for this treatment? _____		

5. <b>During the past 4 months</b> , have you had any of the following tests in an <b>NHS hospital</b> <b>because of rheumatoid arthritis</b> ? (If none please enter '0' in the boxes)		
	Number of times	
X-ray	<input type="text"/>	If none enter '0'
CT Scan	<input type="text"/>	If none enter '0'
MRI Scan	<input type="text"/>	If none enter '0'
Blood test (count all blood tests done on one day, as one test)	<input type="text"/>	If none enter '0'
Other ( <i>please specify</i> ) _____	<input type="text"/>	If none enter '0'

6. <b>During the past 4 months</b> , have you been issued free of charge any medical devices, such as collars, orthopaedic devices, or any other products or equipment (including adaptations to your home) <b>by the NHS</b> <b>because of rheumatoid arthritis</b> ?	Yes <input type="checkbox"/> 1	No <input type="checkbox"/> 2
If <b>yes</b> , please list items below.		
<b>Item issued</b>		
1. _____		
2. _____		
3. _____		
4. _____		

**Private health care:** This section is about any treatment that has been paid for by you or your medical insurance.

7. During the past 4 months, how often have you used any of the following **private services** because of rheumatoid arthritis?

Please detail total treatment costs **you paid for by yourself, or paid for by private insurance.** Please do not include any treatments paid for by the NHS. (Round costs to the nearest pound)

	Number of times	Medical Insurance Contribution	Personal Contribution
Private GP	<input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Private Physiotherapist	<input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Private Occupational Therapist	<input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Private Rheumatologist	<input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Private Orthopaedic surgeon	<input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Private other hospital specialist / consultant	<input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Private nurse	<input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Private Podiatrist / Chiropodist	<input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Other (please specify) _____	<input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	£ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

8. During the past 4 months, have you spent one or more nights in a private hospital because of rheumatoid arthritis?

Yes <sub>1</sub> No <sub>2</sub>

Was this hospital admission for surgery ?

Yes <sub>1</sub> No <sub>2</sub>

If **yes**, a) in which hospital was the surgery performed? \_\_\_\_\_

b) What was the operation performed? \_\_\_\_\_

c) what were the **total costs borne by medical insurance?** £   
(Please round the total costs to the nearest pound.)

d) what were the **total costs borne by you?** £   
(Please round the total costs to the nearest pound.)

If **no**, what was the reason for the admission? \_\_\_\_\_

9. During the past 4 months, have you attended a **private hospital** as a 'day case' patient (you were admitted to the hospital for tests or treatment but you did not stay overnight) **because of rheumatoid arthritis**?

Yes <sub>1</sub> No <sub>2</sub>

If **yes**, a) how many times did you attend ? \_\_\_\_\_ times

b) Were these 'day case' attendances for receiving medication ? Yes <sub>1</sub> No <sub>2</sub>

(i) If **yes**, what medication did you receive? \_\_\_\_\_

(ii) If **no**, please state reason \_\_\_\_\_

c) which hospital did you attend for this treatment? \_\_\_\_\_

d) what were the **total costs borne by medical insurance**? £ 

--	--	--	--	--	--

  
(Please round the total costs to the nearest pound.)

e) what were the **total costs borne by you**? £ 

--	--	--	--	--	--

  
(Please round the total costs to the nearest pound.)

10. During the past 4 months, have you had any of the following tests in a **private hospital** **because of rheumatoid arthritis**?

	Number of times		
X-ray			If none enter '0'
CT Scan			If none enter '0'
MRI Scan			If none enter '0'
Blood test (count all blood tests done on one day, as one test)			If none enter '0'
Other ( <i>please specify</i> ) _____			If none enter '0'

11. During the past 4 months, have you bought (other than by a prescription) any of the following medicinal products **because of rheumatoid arthritis** ?

	Number of times		
Pain killers (for example, paracetamol)			
Anti-inflammatory tablets (for example, ibuprofen)			
Gels/Creams (for example, ibuleve or movelat)			



12. During the past 4 months, have you bought medical devices, such as collars, orthopaedic devices, or any other products or equipment because of rheumatoid arthritis?

Yes	No
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

If yes, please list items and enter cost below to the nearest pound.

**Item Bought**

1. _____	£	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. _____	£	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. _____	£	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. _____	£	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5. _____	£	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**That is the end of this questionnaire.**

Please check that you have completed all sections and return your completed questionnaire to the research clinician.

Please feel free to write any notes for the research team in the space below, and continue over the page, if necessary.

Thank you very much for your time.



PARTICIPANTS ID:

# Strengthening And stretching for Rheumatoid Arthritis of the Hand (SARAH) Trial

**12 month**

## **Research Clinic Assessment Form**

If you need to get in touch with the SARAH Trial research team, please contact:

SARAH Trial team  
Warwick Clinical Trials Unit



Phone:   
Fax:   
E-mail:

**Section 1**

This section is to ensure the research team have sufficient details about the assessment that you are performing. **Please ensure that you have entered the participant's ID number on the front cover of this assessment form.**

1. Date you are completing this assessment:

D	D	M	M	Y	Y	Y	Y

2. Time that you began completing this assessment (24 hour clock):

H	H	M	M

3. Centre ID:

--	--	--	--	--	--	--	--

4. Research clinician's name:

--	--	--	--	--	--	--	--

**Section 2**

This section relates to information about the participant provided from blood tests **that you will need to collect from their medical records.**

1. Latest CRP level (mg/l):

--	--	--

2. Date latest CRP was measured:

D	D	M	M	Y	Y	Y	Y

3. Latest ESR level (mm/hour):

--	--	--

4. Date latest ESR was measured:

D	D	M	M	Y	Y	Y	Y

5. Has the participant suffered from any of the following in the last 8 months? (please circle)

- Tendon rupture in the hand or wrist
- Flare up of hand and/or wrist symptoms for longer than 1 week

**Nb: if participant has suffered from a tendon rupture, then DO NOT go any further with the assessment.**

**Section 3**

This section relates to the medication that the participant is taking. **This information can be provided by the participant or you may need to collect it from their medical records.**

3. Prescribed current medications:			
Drug	Yes	Dose	How often
Ibuprofen	<input type="checkbox"/> 1		
Naproxen	<input type="checkbox"/> 2		
Diclofenac	<input type="checkbox"/> 3		
Indomethacin	<input type="checkbox"/> 4		
Other non-steroidal anti-inflammatory	<input type="checkbox"/> 5		
Sulfasalazine	<input type="checkbox"/> 6		
Hydroxychloroquine	<input type="checkbox"/> 7		
Methotrexate	<input type="checkbox"/> 8		
Gold injections	<input type="checkbox"/> 9		
Leflunomide	<input type="checkbox"/> 10		
Azathioprine	<input type="checkbox"/> 11		
Prednisolone	<input type="checkbox"/> 12		
Infliximab [Remicade]	<input type="checkbox"/> 13		
Etanercept [Enbrel]	<input type="checkbox"/> 14		
Adalimumab [Humira]	<input type="checkbox"/> 15		
Other:	<input type="checkbox"/> 16		

4. Any additional 'as required' medications (only those used in last 7 days):	
Drug	Yes
Extra non-steroidal anti-inflammatory	<input type="checkbox"/> 1
Steroid tablet	<input type="checkbox"/> 2
Steroid injection into joint	<input type="checkbox"/> 3
Steroid injection into muscle	<input type="checkbox"/> 4

**Section 4**

**Measuring Metacarpophalangeal (MCP) Joint Deformity**

Participants should be advised to sit comfortably in a chair, with their forearms and hands supported on a table in front in a pronated position (palm facing down). All potentially interfering jewellery should be removed.

When measuring MCP joint deformity, a goniometer is placed on the back of the hand. The centre of the goniometer is placed over the MCP joint, with one arm placed along the midline of the finger (centred over the PIP joint), and the other arm placed along the associated metacarpal, lining the 180 degree marker up with the midline of the finger (see figure below). This process should be repeated for all four fingers on each hand.

**NB:** Ulnar deviation (fingers bent away from thumb) is recorded as a positive value.  
 Radial deviation (fingers bent towards the thumb) is recorded as a negative value.

In this example, all values would be recorded as positive as all the fingers bend away from the thumb.



Figure 4.1. Measuring MCP joint deformity



MCP Joint Deformity (degrees)

	Left hand	Right hand
Index finger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Middle finger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Ring finger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Little finger	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

**Section 5**

**Measuring Active Wrist Flexion**

Participants should be advised to sit comfortably in a chair with their elbow supported on a table in front of them and all potentially interfering jewellery removed.

The elbow is bent to approximately 90 degrees and the wrist should be in a neutral position (palm neither facing up nor down, similar to an 'arm wrestling' position).

When measuring wrist flexion, a goniometer is placed on the back of the forearm and the hand in line with the midline of the forearm and the metacarpal/phalanx of the middle (3<sup>rd</sup>) finger.

Participants are instructed to "bend your wrist down as far as you can go with your fingers in a relaxed position" and then the measurement should be recorded.

Figure 5.1. Measuring wrist flexion



Active wrist flexion (degrees)

		Left wrist		Right wrist	
Wrist flexion		<input type="text"/>		<input type="text"/>	

**Section 5 (continued)**

**Measuring Active Wrist Extension**

When measuring wrist extension, a goniometer is placed on the palmar side of the forearm and the hand (as shown in Figure 5.2), in line with the midline of the forearm and the middle (3<sup>rd</sup>) metacarpal/phalanx .

Participants are instructed to “bend your wrist back as far as you can go with your fingers in a relaxed position” and then the measurement should be recorded.

Figure 5.2. Measuring wrist extension



Active wrist extension (degrees)

		Left wrist		Right wrist	
Wrist extension		<input type="text"/>		<input type="text"/>	



**Section 5 (continued)**

**Measuring Combined Finger Flexion**

Combined Finger Flexion is a measurement from each distal corner of the nail bed on the radial border (thumb side) to the distal palmar crease of the palm.

To perform a measurement, the elbow is bent to approximately 45 degrees and the wrist should be in a neutral position (palm neither facing up nor down).

Participants are instructed to “make a fist as much as you can” and then the ruler on the end of the goniometer is used to measure the distance between the tip of the distal corner of the nail bed on the radial border (thumb side) to the distal palmar crease of the palm.

Figure 5.3. Measuring Composite Finger Flexion



Combined Finger Flexion (mm)

		Left hand		Right hand	
Index finger		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Middle finger		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ring finger		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Little finger		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Section 5 (continued)**

**Method A - Measuring Composite Finger Extension**

For composite finger extension, the elbow is bent to approximately 45 degrees and palm should be facing down (wrist pronated) to rest flat on the table.

**If the patient is unable to achieve this position (they have flexion deformities) please use the next page**

Participants are instructed to “lift your finger up towards the ceiling as much as you can” and then the ruler on the end of the goniometer is used to measure the distance between the tip of the distal corner of the nail bed on the radial border (thumb side) to the table top. This process is repeated for all the fingers (not the thumb).

**NB:** if the amount of extension is greater than what can be recorded by the ruler, mark the distance on a sheet of paper and then use the ruler to measure this afterwards.

Figure 5.4a. Measuring Composite Finger Extension



Combined Finger Extension (mm)

		Left hand	Right hand	
Index finger		<input type="text"/>	<input type="text"/>	
Middle finger		<input type="text"/>	<input type="text"/>	
Ring finger		<input type="text"/>	<input type="text"/>	
Little finger		<input type="text"/>	<input type="text"/>	

**Section 5 (continued)**

**Method B - Measuring Composite Finger Extension with patients who have finger flexion deformities .**

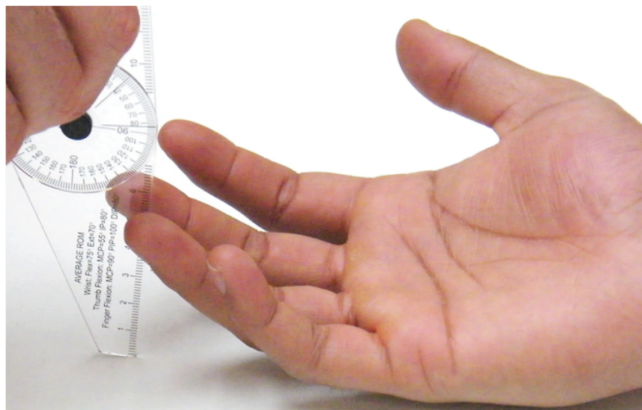
**\* Only use this page if you were unable to complete the previous page \***

For composite finger extension, the elbow is bent to approximately 45 degrees and palm should be facing up (wrist supinated).

Participants are instructed to “try and straighten your fingers towards the table as much as you can” and then the ruler on the end of the goniometer is used to measure the distance between the tip of the distal corner of the nail bed on the radial border (thumb side) to the table top. This process is repeated for all the fingers (not the thumb).

**NB:** if the amount of extension is greater than what can be recorded by the ruler, mark the distance on a sheet of paper and then use the ruler to measure this afterwards.

Figure 5.4b. Measuring Composite Finger Extension for finger flexion deformities



Combined Finger Extension (mm)

	Left hand		Right hand	
Index finger	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Middle finger	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ring finger	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Little finger	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Section 5 (continued)**

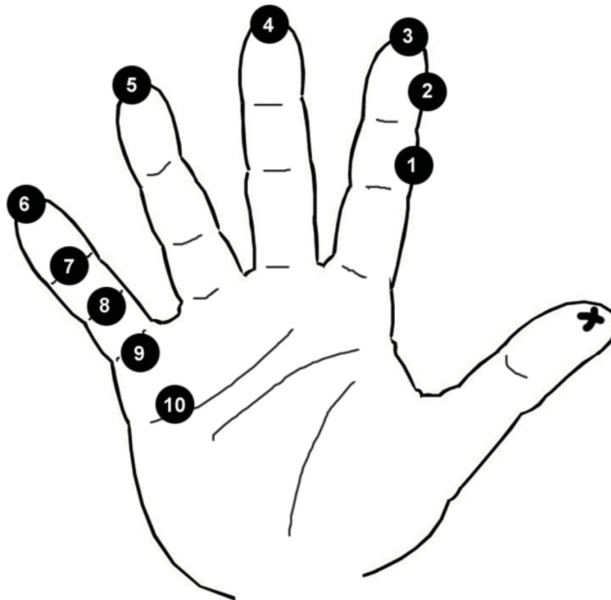
**Thumb Opposition**

The Kapandji test of thumb opposition has been chosen as it offers a simple system of using the hand as a system of reference<sup>30</sup>. The patient is asked to do the following movements with the tip of the thumb (see 'x' on Figure below) :

1. Touch the lateral side of the second phalanx of the index finger
2. Touch the lateral side of the third phalanx of the index finger
3. Touch the tip of the index finger
4. Touch the tip of the middle finger
5. Touch the tip of the ring finger
6. Touch the tip of the little finger
7. Touch the palmar DIP crease of the little finger
8. Touch the palmar PIP crease of the little finger
9. Touch the proximal palmar crease of the little finger
10. Touch the distal palmar crease of the hand

The score is the highest number that the participant can achieve (maximum =10).

Figure 5.5. The 10 points of the Kapandji test of thumb opposition



**Thumb Opposition Score (1-10)**

	Left Thumb		Right Thumb	
Score	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Section 6**

**Swollen & Tender joint count**

Joint swelling is defined as soft tissue swelling that is detectable along the joint margins. Neither bony enlargement nor deformity of the joint constitutes swelling. Each swollen joint should be marked on the diagram below, and the total count should be written in the adjoining boxes.

Joint tenderness is defined as pain at rest that is induced by pressure. The examiner uses his/her thumb and index finger to exert pressure that is sufficient to cause 'whitening' of the examiner's nail beds. Each tender joint should be marked on the diagram below, and the total count should be written in the adjoining boxes.

**Procedure**

Participants should be advised to sit comfortably in a chair, with their forearms and hands supported on a table in front in a pronated position (palm facing down). All potentially interfering jewellery should be removed.

PIP/MCP joints

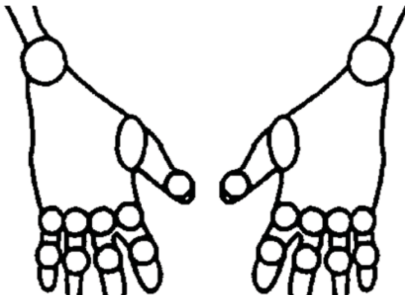
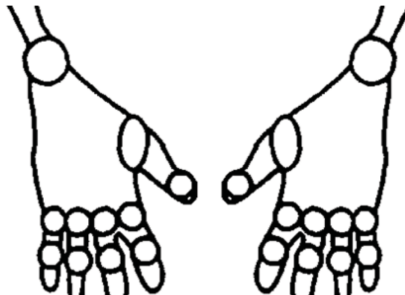
Examine each joint in turn starting with the PIP joints. Examine right and left anterior joint margins using both thumbs while the fingers are supporting the patient's hand. Repeat process on dorsal and palmar joint margins.

Wrist joint

Using the same procedure as above, examine the wrist in the neutral position. Use both hands to examine with thumbs on the dorsal surface and fingers on palmar surface of the patient's wrist.



Please mark each swollen and tender joint on the diagrams below and write the total joint counts in the adjoining boxes.

Swollen Joints	Tender Joints
 <input type="text"/> <input type="text"/> / 22	 <input type="text"/> <input type="text"/> / 22

## **Section 7**

### **Timed upper limb dexterity**

#### 1. The Nine-hole peg test—instructions

The test involves the subject placing 9 dowels in 9 holes, and then removing them. Participants are scored by the amount of time it takes to do this.

For this test you will require:

- A pen
- Nine Hole Peg Test (board and pegs)
- Plastic bowl
- Digital stopwatch

The participant should be:

- Sitting at a desk in a straight-backed chair (without armrests) with their feet flat on the floor.
- The pegboard should be centred in front of the subject.
- A shallow round bowl (or similar container) containing the nine pegs should be placed on the same side as the hand being tested.

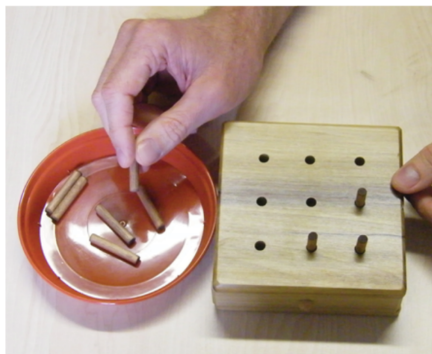
The following instructions should be given to the participant as you briefly demonstrate the test:

“Pick up the pegs one at a time, using your right (or left) hand only and put them into the holes in any order until all the holes are filled. Then remove the pegs one at a time and return them to the container. Stabilise the peg board with your left (or right) hand. This is a practice test. See how fast you can put all the pegs in and take them out again. Are you ready? Go!”

- After the subject completes the practice trial, you say:

“This will be the actual test. The instructions are the same. Work as quickly as you can. Are you ready? Go! [During the test] Fast as you can. [As soon as the last peg is in the board] Out again...as fast as you can.”

- The stopwatch should be started as soon as the subject touched the first peg and stopped when the last peg hit the container.
- The container is then placed on the opposite side of the pegboard. The test is then repeated in the same way for the non-dominant hand.



The Nine-hole peg test—measurements (minutes and seconds)

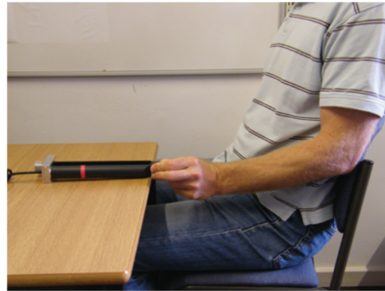
	M	S	S	s	s		
Right upper limb	<input type="text"/>	:	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>
Left upper limb	<input type="text"/>	:	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>

## **Section 8**

### **Full-hand and pinch grip strength—instructions**

#### **Test Position:**

Sitting in a straight-backed chair (without armrests) with feet flat on the floor the participant should be positioned as in the pictures below. Refer to p34 of the manual for full details.



#### **Remember:**

1. For the measurement of full-hand grip, the red band should be positioned closest to the examiner
2. For the measurement of tripod pinch grip, the red band should be positioned on the side of the index and middle finger.
3. Make sure the measuring device is the correct width for the participant and record this on the form.
4. You need to reset the machine before every test. You do this by pushing the “zero” button with the measuring device flat on the table.
5. Ensure the ‘hold’ button remains depressed throughout all tests.

#### **Verbal instructions for each test:**

“When I say “go” I want you to squeeze as hard as you can, and as quickly as you can and hold it for 3 seconds. Go! 1, 2, 3. Stop.”

#### **Order of testing:**

Practice *full-hand* grip with each hand

Dominant hand maximum *full-hand* grip (3 seconds)

30 seconds rest

Non-dominant hand maximum *full-hand* grip (3 seconds)

30 seconds rest

Repeat 3 times in total

Practice *pinch* grip with each hand

Dominant hand maximum *pinch* grip (3 seconds)

30 second rest

Non-dominant hand maximum *pinch* grip (3 seconds)

30 seconds rest

Repeat 3 times in total



**Section 8 (continued)**

**Full-hand and pinch grip strength—measurements**

1. Maximum full-hand grip force (Newtons)

Full grip	Left hand			Right hand		
1st trial						
2nd trial						
3rd trial						

Grip Handle Width used using inside edges (mm):

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2. Maximum 'tripod' pinch grip force (Newtons)

Pinch grip	Left hand			Right hand		
1st trial						
2nd trial						
3rd trial						

**Use the same Grip Handle Width as full-hand grip test**

**Research Clinician to answer:**

**1) Which type of treatment was received by the participant?** *(please circle)*

Don't know -----► (go to question 2)

Usual care only (control)

Usual care + exercise (experimental)

Give reasons for your answer *(please circle)*

Patient said

Patient implied

Change in participants condition

Other: .....

**2) If you don't know, which type of treatment do you think they received?** *(please circle)*

Usual care only (control)

Usual care + exercise (experimental)

Give reasons for your answer *(please circle)*

Patient said

Patient implied

Change in participants condition

Other: .....

Please check that all sections have been completed .

**Please ensure that you have entered the participant's ID number on the front cover of this questionnaire.**

Please write any notes you have for the SARAH trial team in the space below.

Thank you very much for your time.