**Report Supplementary Material 16** Three Month Patient Questionnaire

THE UNIVERSITY of York

South Tees Hospitals NHS
NHS Foundation Trust

**CONFIDENTIAL**

# United Kingdom Frozen Shoulder Trial (UK FROST)

## Three month patient questionnaire from entering the study

**Please use a black or blue pen to complete the questionnaire**

**There are no right or wrong answers – answer the questions as honestly as you can**

**The responses you give will be treated in the utmost confidence**

*For office use only:*

**Participant ID Number:** | | | | |

**Date questionnaire sent:** | | | / | | | / | | | | |
*day* *month* *year*

**Date questionnaire completed:** | | | / | | | / | | | | |
*day* *month* *year*

## Section 1: PROBLEMS WITH YOUR SHOULDER

Please tick (✓) one box for every question.

**1. During the past 4 weeks...**

How would you describe the **worst** pain you had from your shoulder?

| None | Mild | Moderate | Severe | Unbearable |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**2. During the past 4 weeks...**

Have you had any trouble dressing yourself because of your shoulder?

| No trouble at all | A little bit of trouble | Moderate trouble | Extreme difficulty | Impossible to do |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**3. During the past 4 weeks...**

Have you had any trouble getting in and out of a car or using public transport because of your shoulder? (whichever you tend to use)

| No trouble at all | A little bit of trouble | Moderate trouble | Extreme difficulty | Impossible to do |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**4. During the past 4 weeks...**

Have you been able to use a knife and fork - at the same time?

| Yes, easily | With little difficulty | With moderate difficulty | With extreme difficulty | No, impossible |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**5. During the past 4 weeks...**

**Could** you do the household shopping on your own?

| Yes, easily | With little difficulty | With moderate difficulty | With extreme difficulty | No, impossible |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**6. During the past 4 weeks...**

**Could** you carry a tray containing a plate of food across a room?

| Yes, easily | With little difficulty | With moderate difficulty | With extreme difficulty | No, impossible |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**7. During the past 4 weeks...**

**Could** you brush/comb your hair with the affected arm?

| Yes, easily | With little difficulty | With moderate difficulty | With extreme difficulty | No, impossible |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**8. During the past 4 weeks...**

How would you describe the pain you usually had from your shoulder?

| None | Very mild | Mild | Moderate | Severe |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**9. During the past 4 weeks...**

**Could** you hang your clothes up in a wardrobe, using the affected arm?

| Yes, easily | With little difficulty | With moderate difficulty | With great difficulty | No, impossible |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**10. During the past 4 weeks...**

Have you been able to wash and dry yourself under both arms?

| Yes, easily | With little difficulty | With moderate difficulty | With extreme difficulty | No, impossible |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**11. During the past 4 weeks...**

How much has pain from your shoulder interfered with your usual work (including housework)?

| Not at all | A little bit | Moderately | Greatly | Totally |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**12. During the past 4 weeks...**

Have you been troubled by pain from your shoulder in bed at night?

| No nights | Only 1 or 2 nights | Some nights | Most nights | Every night |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Please check back that you have answered each of the previous twelve questions and then continue with the rest of the questionnaire.**

The following questions ask about your symptoms as well as your ability to perform certain activities. Please answer *every question*, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* of which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

**Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.**

| | | NO DIFFICULTY | MILD DIFFICULTY | MODERATE DIFFICULTY | SEVERE DIFFICULTY | UNABLE |
|---|---|---|---|---|---|---|
| 1. | Open a tight or new jar. | 1 | 2 | 3 | 4 | 5 |
| 2. | Do heavy household chores (e.g. wash walls, floors). | 1 | 2 | 3 | 4 | 5 |
| 3. | Carry a shopping bag or briefcase. | 1 | 2 | 3 | 4 | 5 |
| 4. | Wash your back. | 1 | 2 | 3 | 4 | 5 |
| 5. | Use a knife to cut food. | 1 | 2 | 3 | 4 | 5 |
| 6. | Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.). | 1 | 2 | 3 | 4 | 5 |

| | | NOT AT ALL | SLIGHTLY | MODERATELY | QUITE A BIT | EXTREMELY |
|---|---|---|---|---|---|---|
| 7. | During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? | 1 | 2 | 3 | 4 | 5 |

| | | NOT LIMITED AT ALL | SLIGHTLY LIMITED | MODERATELY LIMITED | VERY LIMITED | UNABLE |
|---|---|---|---|---|---|---|
| 8. | During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? | 1 | 2 | 3 | 4 | 5 |

| **Please rate the severity of the following symptoms in the last week.** *(circle number)* | | NONE | MILD | MODERATE | SEVERE | EXTREME |
|---|---|---|---|---|---|---|
| 9. | Arm, shoulder or hand pain. | 1 | 2 | 3 | 4 | 5 |
| 10. | Tingling (pins and needles) in your arm, shoulder or hand. | 1 | 2 | 3 | 4 | 5 |

| | | NO DIFFICULTY | MILD DIFFICULTY | MODERATE DIFFICULTY | SEVERE DIFFICULTY | SO MUCH DIFFICULTY THAT I CAN'T SLEEP |
|---|---|---|---|---|---|---|
| 11. | During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand *(circle number)* | 1 | 2 | 3 | 4 | 5 |

**Shoulder Pain Question**

Please select the number below that best describes how bad your shoulder pain has been during the past 24 hours. *(Circle one number only).*

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | | | | | | | | | | **Worst possible pain** |

## Section 2: This section asks about your health in general

Under each heading, please tick the **ONE** box that best describes your health **TODAY**.

**MOBILITY**

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

**SELF-CARE**

- I have no problems washing or dressing myself ☐
- I have slight problems washing or dressing myself ☐
- I have moderate problems washing or dressing myself ☐
- I have severe problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

**USUAL ACTIVITIES** *(e.g. work, study, housework, family or leisure activities)*

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

**PAIN/DISCOMFORT**

- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

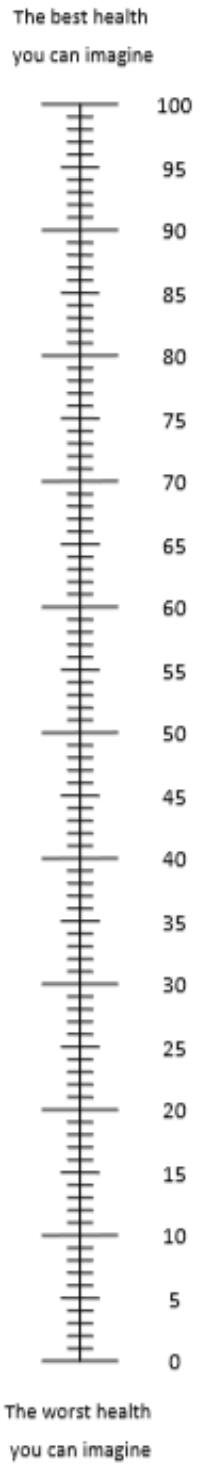
**ANXIETY/DEPRESSION**

- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐
- I am extremely anxious or depressed ☐

- We would like to know how good or bad your health is TODAY.
- The scale is numbered from 0 to 100.
- 100 means the <u>best</u> health you can imagine.

  0 means the <u>worst</u> health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = | | | |

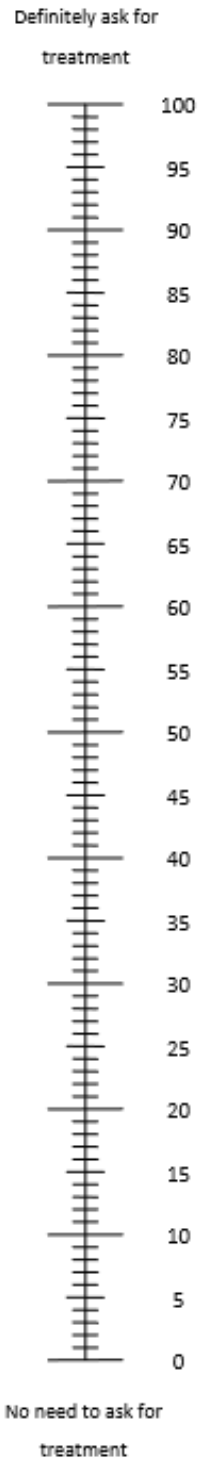


**We would like to know to what extent your frozen shoulder symptoms in the past 24 hours would prompt you to ask for further treatment.**

- This scale is numbered from 0 to 100.
- 0 means that you feel you *do not need* to ask for further treatment for your frozen shoulder
  100 means that you *definitely need to* ask for further treatment.
- Mark an X on the scale to indicate the extent of your frozen shoulder symptoms in prompting you to ask for further treatment.

**Now, please write the number you marked on the scale in the box below.**

I MARKED THE SCALE AT | | | |



**Section 3: This final section asks about the health care you have received over the past three months.**

If the health care you received was related to your shoulder, record this in the "**About your shoulder**" column. If the health care was for any other reason, enter this in the "**Other reasons**" column".

**Please fill in all of the boxes, for example:**

If you have seen your 'family doctor **at your GP practice'** as many as ten times in the **past three months** related to your shoulder then in the **"About your shoulder"** column record a "10" in the box.

If you have not seen your 'family doctor at your GP practice' in the **past three months** for any other reason then in the **"Other reasons"** column record a "0" in the box.

| | About your shoulder | Other reasons |
|---|---|---|
| Example: Seen your family doctor **at your GP practice?** | 1 0 | 0 |

**Care from the NHS NOT in the hospital:** Over **the past three months**, how many times have you:

| | | About your shoulder | Other reasons |
|---|---|---|---|
| 1. | Seen your family doctor **at your GP practice?** *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |
| 2. | Seen your family doctor **at home?** *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |
| 3. | Spoken to your family doctor **by phone?** *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |
| 4. | Seen a physiotherapist at your GP practice? *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |
| 5. | Seen a nurse at your GP practice? *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |
| 6. | Seen a district/community nurse? *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |
| 7. | Seen an occupational therapist **at home?** *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |

**Care from the NHS IN in the hospital:** Over the **past three months**, how many times have you:

| | About your shoulder | Other reason |
|---|---|---|
| 8. Seen an occupational therapist **in hospital?** *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |
| 9. Attended a hospital clinic? *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |
| 10. Attended Accident and Emergency? *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |
| 11. Visited hospital as a **day case** (i.e. admitted and discharged in the same day)? *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |
| 12. How many nights have you stayed in hospital as an **in-patient?** (i.e. admitted and discharged on a different day) *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |

**Private treatments**: Could you tell us please about **any additional medical treatments you have received, which you have paid for**. Over the **past three months**, how many times have you:

| | About your shoulder | Other reason |
|---|---|---|
| 13. Seen a non-NHS physiotherapist? *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |
| 14. Seen an osteopath? *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |
| 15. Seen a chiropractitioner? *(please record the number of times in the boxes)* | *If none enter '0'* | *If none enter '0'* |

16. If you have paid to see any other health care professional (e.g. acupuncturist) then for each type of person that you have seen record this in the box(es) below: *(please record the number of times in the boxes)*

| | About your shoulder | Other reason |
|---|---|---|
| _____ | *If none enter '0'* | *If none enter '0'* |
| _____ | *If none enter '0'* | *If none enter '0'* |

| | About your shoulder | Other reason |
|---|---|---|
| 17. Have you visited a private hospital as a **day case** (i.e. admitted and discharged in the same day)? *(please record the number of times in the boxes)* | ☐☐ *If none enter '0'* | ☐☐ *If none enter '0'* |
| 18. How many nights have you stayed in a private hospital as an **in-patient**? (i.e. admitted and discharged on a different day)? *(please record the number of times in the boxes)* | ☐☐ *If none enter '0'* | ☐☐ *If none enter '0'* |

**Medications**

19. Over the **past three months**, have you taken any **prescribed medication** to relieve the pain for **your shoulder problem**?
*(please cross one box only)* ☐ Yes* ☐ No

* If '**Yes**', please cross the box(es) in the table below to record the medication you were prescribed and the number of days taken over the **past three months**.

| Name of medication | | Number of days | Name of medication | | Number of days |
|---|---|---|---|---|---|
| Paracetamol | ☐ | ☐☐ | Tramadol | ☐ | ☐☐ |
| Ibuprofen | ☐ | ☐☐ | Diclofenac | ☐ | ☐☐ |
| Aspirin | ☐ | ☐☐ | Other | | ☐☐ |
| Co-codamol | ☐ | ☐☐ | Other | | ☐☐ |
| Codeine Phosphate | ☐ | ☐☐ | Other | | ☐☐ |

20. Over the **past three months**, have you taken any **over the counter medication** to relieve the pain for **your shoulder problem**?
*(please cross one box only)* ☐ Yes* ☐ No

* If '**Yes**', please cross the box(es) in the table below to record the medication you have paid for yourself and the number of days taken over the **past three months.**

| Name of medication | | Number of days | Name of medication | | Number of days |
|---|---|---|---|---|---|
| Paracetamol | ☐ | ☐☐ | Diclofenac | ☐ | ☐☐ |
| Ibuprofen | ☐ | ☐☐ | Other | | ☐☐ |
| Aspirin | ☐ | ☐☐ | Other | | ☐☐ |

**Return to work and recreational activities**

21. **If you are in paid** employment, how many working days over the **past three months** have you missed because of **your shoulder problem**? ☐☐ *days*

22. For how many days over the **past three months** have you been unable to perform your normal UNPAID activities (e.g. household chores, shopping, helping others) because of **your shoulder problem**? ☐☐ *days*

**Please post the questionnaire back to us using the freepost envelope provided.**

**Please let us know of anything that you think we have not asked that is badly affecting your everyday activities because of your shoulder problem.**

**If you have any other comments about your shoulder problem, this study, or this questionnaire, please write them here.**

***THANK YOU VERY MUCH* FOR COMPLETING THIS QUESTIONNAIRE**