These next questions ask about Muscle Cramps or Spasms.

1. Please rate how severe your muscle cramps or spasms are on the 0 to 10 scale below by selecting a number that best fits how severe your cramps are at their WORST:

   0  1  2  3  4  5  6  7  8  9  10
   No cramps or spasms at all
   Cramps or spasms as bad as they can possibly be

   IF you answer: ‘0’ on question 1, please SKIP to question 2 on the next page.

   IF you answer: from ‘1’ to ‘10’ on question 1, please ANSWER questions 1a through 1d.

   1a. When do you have muscle cramps or spasms?

      □ 0  Never
      □ 1  Only when exercising
      □ 2  Only at night
      □ 3  Only in the daytime
      □ 4  Day and night

   1b. How much of the time do you have muscle cramps or spasms in a usual month? (Please select the one that fits best for you.)

      □ 9  All the time
      □ 8  More than twice every day
      □ 7  Once or twice a day
      □ 6  Several times a week but not every day
      □ 5  A few times a month or about once a week
      □ 4  About once a month or less
      □ 3  Only with certain activities or movements such as exercising
      □ 2  Only at certain times of the day such as evening, nights, or mornings
      □ 1  It is completely unpredictable
      □ 0  Never

   1c. Please rate how severe your muscle cramps or spasms are on the 0 to 10 scale below by selecting a number that best fits how severe your cramps are usually or most of the time:

      0  1  2  3  4  5  6  7  8  9  10
      No cramps or spasms at all
      Cramps or spasms as bad as they can possibly be

   1d1. Do cramps or spasms wake you when you are sleeping or make it difficult to get to sleep?

      □ 0  Rarely or not at all
      □ 1  Less than once a week
      □ 2  One to 2 times a week
      □ 3  3 to 5 times a week, or more
1d2. How much do cramps or spasms impact your emotional well-being?

☐ 0 Not at all
☐ 1 Mildly
☐ 2 Moderately
☐ 3 Extremely

How much do muscle cramps or spasms limit or prevent each of these activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>No, not limited at all</th>
<th>Yes, limited a little</th>
<th>Yes, limited a lot</th>
<th>Yes, muscle cramps stop me from doing this activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1d3. Physical activities like sports or exercise</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>1d4. Sitting or standing</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>1d5. Social activity</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
</tbody>
</table>

These next questions ask about Muscle Weakness.

2. Please rate how severe your muscle weakness is on the 0 to 10 scale below by selecting a number that best fits how severe your weakness is at its WORST:

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not weak at all</td>
</tr>
<tr>
<td>1</td>
<td>As weak as can possibly be</td>
</tr>
<tr>
<td>2</td>
<td>All the time</td>
</tr>
<tr>
<td>3</td>
<td>More than twice every day</td>
</tr>
<tr>
<td>4</td>
<td>Once or twice a day</td>
</tr>
<tr>
<td>5</td>
<td>Several times a week but not every day</td>
</tr>
<tr>
<td>6</td>
<td>A few times a month or about once a week</td>
</tr>
<tr>
<td>7</td>
<td>About once a month or less</td>
</tr>
<tr>
<td>8</td>
<td>Only with certain activities or movements such as exercising</td>
</tr>
<tr>
<td>9</td>
<td>Only at certain times of the day such as evening, nights, or mornings</td>
</tr>
<tr>
<td>10</td>
<td>It is completely unpredictable</td>
</tr>
</tbody>
</table>

IF you answer: ‘0’ on question 2, please SKIP to question 3 on the next page.

IF you answer: from ‘1’ to ‘10’ on question 2, please ANSWER questions 2a through 2d.

2a. Has a doctor told you that you have muscle weakness related to a “neuropathy” from chemotherapy?

☐ 0 No
☐ 1 Yes
☐ 2 Not sure

2b. How much of the time do you have muscle weakness in a usual month?

(Please select the one that fits best for you.)

☐ 9 All the time
☐ 8 More than twice every day
☐ 7 Once or twice a day
☐ 6 Several times a week but not every day
☐ 5 A few times a month or about once a week
☐ 4 About once a month or less
☐ 3 Only with certain activities or movements such as exercising
☐ 2 Only at certain times of the day such as evening, nights, or mornings
☐ 1 It is completely unpredictable
☐ 0 Never
2c. Please rate how severe your muscle weakness is on the 0 to 10 scale below by selecting a number that best fits how severe your weakness is usually or most of the time:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not weak at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>As weak as can possibly be</td>
</tr>
</tbody>
</table>

2d1. Does muscle weakness make you need to take naps or sleep longer?
- [ ] Rarely or not at all
- [ ] Less than once a week
- [ ] One to 2 times a week
- [ ] 3 to 5 times a week, or more

2d2. How much does muscle weakness impact your emotional well-being?
- [ ] Not at all
- [ ] Mildly
- [ ] Moderately
- [ ] Extremely

How much does muscle weakness limit or prevent each of these activities?

<table>
<thead>
<tr>
<th>2d3. Physical activities like sports or exercise</th>
<th>No, not limited at all</th>
<th>Yes, limited a little</th>
<th>Yes, limited a lot</th>
<th>Yes, muscle weakness stops me from doing this activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] 0</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
</tr>
</tbody>
</table>

| 2d4. Sitting or standing                      | [ ] 0                  | [ ] 1               | [ ] 2           | [ ] 3                                               |

| 2d5. Social activity                          | [ ] 0                  | [ ] 1               | [ ] 2           | [ ] 3                                               |

These next questions ask about Other Muscle Problems such as aches, pains, or stiffness (including back or shoulder problems that are in your muscles). Please do not include problems that are in your bones or joints. We will ask about those later.

3. Please rate how severe your muscle problems are on the 0 to 10 scale below. Select the number that best fits how severe your aches, pains, stiffness or other muscle problems are at their WORST:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No muscle pain or muscle problems at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Muscle pain or other muscle problems as bad as can possibly be</td>
</tr>
</tbody>
</table>

IF you answer: ‘0’ on question 3, please SKIP to question 4 on the next page.

IF you answer: from ‘1’ to ‘10’ on question 3, please ANSWER questions 3a through 3c.
3a. **How much of the time** do you have these aches, pains, stiffness or other muscle problems **in a usual month**? *(Please select the one that fits best for you.)*

- □ 9 All the time
- □ 8 More than twice every day
- □ 7 Once or twice a day
- □ 6 Several times a week but not every day
- □ 5 A few times a month or about once a week
- □ 4 About once a month or less
- □ 3 Only with certain activities or movements such as exercising
- □ 2 Only at certain times of the day such as evening, nights, or mornings
- □ 1 It is completely unpredictable
- □ 0 Never

3b. Please rate **how severe** your muscle problems are on the 0 to 10 scale below. Select the number that best fits how severe your aches, pains, stiffness or other muscle problems are **usually or most of the time**:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No muscle pain or muscle problems at all</td>
<td>Muscle pain or muscle problems as bad as can possibly be</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3c1. Do muscle aches or pains, stiffness or other problems **wake you** when you are sleeping or make it difficult to get to sleep?

- □ 0 Rarely or not at all
- □ 1 Less than once a week
- □ 2 One to 2 times a week
- □ 3 3 to 5 times a week, or more

3c2. How much do muscle aches or pains, stiffness or other problems **impact your emotional well-being**?

- □ 0 Not at all
- □ 1 Mildly
- □ 2 Moderately
- □ 3 Extremely

**How much do muscle aches, pains, stiffness or other problems limit or prevent each of these activities?**

<table>
<thead>
<tr>
<th></th>
<th>No, not limited at all</th>
<th>Yes, limited a little</th>
<th>Yes, limited a lot</th>
<th>Yes, muscle problems stop me from doing this activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>3c3. Physical activities like sports or exercise</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>3c4. Sitting or standing</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td>3c5. Social activity</td>
<td>□ 0</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
</tbody>
</table>

4. Have you ever had a hip or other joint replacement?

- □ 0 No  ➔ IF NO, please go to question 5
- □ 1 Yes  ➔ IF YES, please answer the next question
4a. Where have you had joint replacements? *(Select as many as apply to you.)*

- Hip(s)
- Knee(s)
- Shoulders
- Other, please describe: ________________________________________________

These next questions ask about **Joint or Spine problems such as aching, pain, swelling or stiffness.** Please do not include loss of bone density (osteoporosis or osteopenia).

5. Please rate **how severe** your joint or spine problems are on the 0 to 10 scale below by selecting the number that best fits how severe your problems are **at their WORST:**

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No joint problems at all</td>
<td>Joint problems as bad as can possibly be</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IF you answer: ‘0’ on question 5, please SKIP to question 6 on the next page.**

**IF you answer: from ‘1’ to ‘10’ on question 5, please ANSWER questions 5a through 5d.**

5a. **Where** do you have **Joint or Spine** problems? *(Select as many as apply to you.)*

- Hips
- Knees
- Hands or fingers
- Shoulders
- Spine (please do not include problems only in your neck)
- Other places, Please describe: ______________________________________________

5b. **How much of the time** do you have **Joint or Spine** problems **in a usual month?** *(Please select the one that fits best for you.)*

- All the time
- More than twice every day
- Once or twice a day
- Several times a week but not every day
- A few times a month or about once a week
- About once a month or less
- Only with certain activities or movements such as exercising
- Only at certain times of the day such as evening, nights, or mornings
- It is completely unpredictable
- Never

5c. **How much difficulty** do you have, or how limited are you, when moving your joints or spine?

- Not at all
- Mildly
- Moderately
- Severely
5d. Please rate how severe your joint or spine problems are on the 0 to 10 scale below by selecting the number that best fits how severe your problems are **USUALLY** or most of the time:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No joint problems at all</td>
<td>Joint problems as bad as can possibly be</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5e1. Do joint or spine problems **wake you** when you are sleeping or make it difficult to get to sleep?

- [ ] 0 Rarely or not at all
- [ ] 1 Less than once a week
- [ ] 2 One to 2 times a week
- [ ] 3 3 to 5 times a week, or more

5e2. How much do joint or spine problems **impact your emotional well-being**?

- [ ] 0 Not at all
- [ ] 1 Mildly
- [ ] 2 Moderately
- [ ] 3 Extremely

---

**How much do joint or spine problems limit or prevent each of these activities?**

<table>
<thead>
<tr>
<th>Activity</th>
<th>No, not limited at all</th>
<th>Yes, limited a little</th>
<th>Yes, limited a lot</th>
<th>Yes, joint problems stop me from doing this activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>5e3. Physical activities like sports or exercise</td>
<td>[ ] 0</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
</tr>
<tr>
<td>5e4. Sitting or standing</td>
<td>[ ] 0</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
</tr>
<tr>
<td>5e5. Walking</td>
<td>[ ] 0</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
</tr>
<tr>
<td>5e6. Social activity</td>
<td>[ ] 0</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
</tr>
</tbody>
</table>

6. Have you had any **Bone or Spine Fractures** (broken bones) since your treatment?

- [ ] 0 No
- [ ] 1 Yes ➔ Please answer Questions 6a and 6b

**IF YES:**

6a. **How many** fractures have you had **since your treatment**?

- [ ] 0 None
- [ ] 1 One
- [ ] 2 Two or more – **IF MORE THAN 2**: How many since your treatment? ________________

6b. **How** did you **get** the fractures? *(Select as many as apply to you.)*

- [ ] 1 I fell or caused the fracture by my actions
- [ ] 1 Someone else ran into me or caused the fracture
- [ ] 1 Nothing happened that I can recall, I just found out that I had a broken bone
- [ ] 1 Other, Please describe __________________________________________________________________________

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