

MJM (MUSCLE and JOINT MEASURE)

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?				
	No, not limited at all	Yes, limited a little	Yes, limited a lot	Yes, muscle cramps stop me from doing this activity
1d3. Physical activities like sports or exercise	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
1d4. Sitting or standing	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
1d5. Social activity	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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**:

- 0 1 2 3 4 5 6 7 8 9 10**
 Not weak at all As weak as can possibly be

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**:

0 1 2 3 4 5 6 7 8 9 10
 Not weak at all As weak as can possibly be

2d1. Does muscle weakness make you need to **take naps or sleep longer**?

- 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

2d2. How much does muscle weakness **impact your emotional well-being**?

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

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

	No, not limited at all	Yes, limited a little	Yes, limited a lot	Yes, muscle weakness stops me from doing this activity
2d3. Physical activities like sports or exercise	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2d4. Sitting or standing	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2d5. Social activity	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> 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**:

0 1 2 3 4 5 6 7 8 9 10
 No muscle pain or muscle problems at all Muscle pain or other muscle problems as bad as can possibly be

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:**

0	1	2	3	4	5	6	7	8	9	10
No muscle pain or muscle problems at all										Muscle pain or muscle problems as bad as can possibly be

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?

	No, not limited at all	Yes, limited a little	Yes, limited a lot	Yes, muscle problems stop me from doing this activity
3c3. Physical activities like sports or exercise	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3c4. Sitting or standing	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3c5. Social activity	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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.)

- ₁ Hip(s)
₁ Knee(s)
₁ Shoulders
₁ 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**:

- | | | | | | | | | | | |
|--------------------------------|---|---|---|---|---|---|---|---|---|--|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| No joint
problems
at all | | | | | | | | | | Joint problems
as bad as can
possibly be |

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.)

- ₁ Hips
₁ Knees
₁ Hands or fingers
₁ Shoulders
₁ Spine (please do not include problems only in your neck)
₁ 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.)

- 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

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

- ₀ Not at all
₁ Mildly
₂ Moderately
₃ 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**:

- | | | | | | | | | | | |
|--------------------------|----------|----------|----------|----------|--|----------|----------|----------|----------|-----------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| No joint problems at all | | | | | Joint problems as bad as can possibly be | | | | | |

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?

	No, not limited at all	Yes, limited a little	Yes, limited a lot	Yes, joint problems stop me from doing this activity
5e3. Physical activities like sports or exercise	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
5e4. Sitting or standing	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
5e5. Walking	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
5e6. Social activity	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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
