

ENG_Generalized Anxiety Disorder 7 Item (GAD 7) Scale

Please complete the survey below.

Thank you!

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all sure	Several days	Over half the days	Nearly every day
1) 1. Feeling nervous, anxious, or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) 2. Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) 3. Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) 4. Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) 5. Being so restless that it's hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6) 6. Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7) 7. Feeling afraid as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<hr/>				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
8) If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

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ENG_Two Simple Questions (TSQ)

Please complete the survey below.

Thank you!

1. During the past two weeks, have you needed help from another person to manage your daily activities?

- No
 Yes

1a. If yes, is this a new situation after the heart attack?

- No
 Yes
 Not applicable (answered no to question 1)

2. Do you feel that you have achieved a complete mental recovery after your heart attack?

- No
 Yes

ENG_PTSD Checklist for DSM-5 (PCL-5) Scored

Please complete the survey below.

Thank you!

PCL-5

Instructions: Below is a list of problems people sometimes have in response to a stressful experience. Please read each problem carefully and then click one of the options to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1) 1. Repeated, disturbing, and unwanted memories of the stressful experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) 2. Repeated, disturbing dreams of the stressful experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) 3. Suddenly feeling or acting as if the stressful experience was actually happening again (as if you were actually back there reliving it)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) 4. Feeling very upset when something reminded you of the stressful experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) 5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6) 6. Avoiding memories, thoughts, or feelings related to the stressful experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7) 7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8) 8. Trouble remembering important parts of the stressful experience?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9)					

ENG_Subjective cogniton Single Item

Please complete the survey below.

Thank you!

1) How do you experience your memory, concentration, and/or planning ability today compared to before the cardiac arrest?

- It is much better
- It is better
- It is unchanged
- It is worse
- It is much worse

- | | | | | | | |
|-------|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 9. | Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10) | 10. Blaming yourself or someone else for the stressful experience or what happened after it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11) | 11. Having strong negative feelings such as fear, horror, anger, guilt, or shame? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12) | 12. Loss of interest in activities that you used to enjoy? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13) | 13. Feeling distant or cut off from other people? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14) | 14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15) | 15. Irritable behavior, angry outbursts, or acting aggressively? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16) | 16. Taking too many risks or doing things that could cause you harm? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 17) | 17. Being "superalert" or watchful or on guard? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 18) | 18. Feeling jumpy or easily startled? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 19) | 19. Having difficulty concentrating? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 20) | 20. Trouble falling or staying asleep? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <hr/> | | | | | | |
| 21) | PTSD Checklist score | <hr/> | | | | |

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress, 28*(6), 489-498. h

ENG_Patient Health Questionnaire (PHQ) 9

Please complete the survey below.

Thank you!

**Over the last 2 weeks how often have you been bothered by any of the following problems?
(Click the circle to indicate your answer)**

- | | |
|---|---|
| 1) 1. Little interest or pleasure in doing things | <input type="radio"/> 0- Not at all
<input type="radio"/> 1- Several days
<input type="radio"/> 2- More than half the days
<input type="radio"/> 3- Nearly every day |
| 2) 2. Feeling down, depressed, or hopeless | <input type="radio"/> 0- Not at all
<input type="radio"/> 1- Several days
<input type="radio"/> 2- More than half the days
<input type="radio"/> 3- Nearly every day |
| 3) 3. Trouble falling or staying asleep, or sleeping too much | <input type="radio"/> 0- Not at all
<input type="radio"/> 1- Several days
<input type="radio"/> 2- More than half the days
<input type="radio"/> 3- Nearly every day |
| 4) 4. Feeling tired or having little energy | <input type="radio"/> 0- Not at all
<input type="radio"/> 1- Several days
<input type="radio"/> 2- More than half the days
<input type="radio"/> 3- Nearly every day |
| 5) 5. Poor appetite or overeating | <input type="radio"/> 0- Not at all
<input type="radio"/> 1- Several days
<input type="radio"/> 2- More than half the days
<input type="radio"/> 3- Nearly every day |
| 6) 6. Feeling bad about yourself -- or that you are a failure or have let yourself or your family down | <input type="radio"/> 0- Not at all
<input type="radio"/> 1- Several days
<input type="radio"/> 2- More than half the days
<input type="radio"/> 3- Nearly every day |
| 7) 7. Trouble concentrating on things, such as reading the newspaper or watching television | <input type="radio"/> 0- Not at all
<input type="radio"/> 1- Several days
<input type="radio"/> 2- More than half the days
<input type="radio"/> 3- Nearly every day |
| 8) 8. Moving or speaking so slowly that other people could have noticed? Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual | <input type="radio"/> 0- Not at all
<input type="radio"/> 1- Several days
<input type="radio"/> 2- More than half the days
<input type="radio"/> 3- Nearly every day |
| 9) 9. Thoughts that you would be better off dead or of hurting yourself in some way | <input type="radio"/> 0- Not at all
<input type="radio"/> 1- Several days
<input type="radio"/> 2- More than half the days
<input type="radio"/> 3- Nearly every day |
| 10) Enter Total Score: | _____ |

-
- 11) If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
- 1- Not difficult at all
 - 2- Somewhat difficult
 - 3- Very difficult
 - 4- Extremely difficult

Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a Brief Depression Severity Measure. *J Gen Intern Med.* 2001 September; 16(9): 606-613.

ENG_Modified Fatigue Impact Scale (MFIS) Scored

Please complete the survey below.

Thank you!

Fatigue is a feeling of physical tiredness and lack of energy that many people experience occasionally.

Following is a list of statements that describe the effects of fatigue. Please read each statement carefully, then select the one number that best indicates how often fatigue has affected you in this way during the past 4 weeks. Please answer every question. If you are not sure which answer to select choose the one answer that comes closest to describing you.

Because of my fatigue during the past 4 weeks...

	Never 0	Rarely 1	Sometimes 2	Often 3	Almost Always 4
1) 1. I have been less alert.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) 2. I have had difficulty paying attention for long periods of time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) 3. I have been unable to think clearly.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) 4. I have been clumsy and uncoordinated.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) 5. I have been forgetful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6) 6. I have had to pace myself in my physical activities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7) 7. I have been less motivated to do anything that requires physical effort.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8) 8. I have been less motivated to participate in social activities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9) 9. I have been limited in my ability to do things away from home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10) 10. I have trouble maintaining physical effort for long periods.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11) 11. I have had difficulty making decisions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12) 12. I have been less motivated to do anything that requires thinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13) 13. My muscles have felt weak	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14)					

- 14) 14. I have been physically uncomfortable.
- 15) 15. I have had trouble finishing tasks that require thinking.
- 16) 16. I have had difficulty organizing my thoughts when doing things at home or at work.
- 17) 17. I have been less able to complete tasks that require physical effort.
- 18) 18. My thinking has been slowed down.
- 19) 19. I have had trouble concentrating.
- 20) 20. I have limited my physical activities.
- 21) 21. I have needed to rest more often or for longer periods.

Instructions for Scoring the MFIS

Items on the MFIS can be aggregated into three subscales (physical, cognitive, and psychosocial), as well as into a total MFIS score. All items are scaled so that higher scores indicate a greater impact of fatigue on a person's activities.

- 22) Physical Subscale _____
- 23) Cognitive Subscale _____
- 24) Psychosocial Subscale _____
- 25) Total MFIS Score _____

The Consortium of Multiple Sclerosis Centers Health Services Research Subcommittee. MSQLI Multiple Sclerosis Quality of Life Inventory: A User's Manual. National Multiple Sclerosis Society. 1997. 65p