# WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

**36-item version, self-administered**

Patient Name:_____ Date:_____

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, mental or emotional problems with alcohol or drugs. Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please check the box that applies

| **In the past 30 days, how much difficulty did you have in :** | | | | | | |
|---|---|---|---|---|---|---|
| | **Understanding and Communicating** | **None** | **Mild** | **Moderate** | **Severe** | **Extreme or Cannot do** |
| D1.1 | Concentrating on doing something for ten minutes? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D1.2 | Remembering to do important things? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D1.3 | Analyzing and finding solutions to problems in day-to-day life? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D1.4 | Learning a new task, for example, learning how to get to a new place? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D1.5 | Generally understanding what people say? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D1.6 | Starting and maintaining a conversation? | ☐ | ☐ | ☐ | ☐ | ☐ |
| | **Getting Around** | **None** | **Mild** | **Moderate** | **Severe** | **Extreme or Cannot do** |
| D2.1 | Standing for long periods such as 30 minutes? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D2.2 | Standing up from sitting down? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D2.3 | Moving around inside your home? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D2.4 | Getting out of your home? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D2.5 | Walking a long distance such as a kilometer [or equivalent | ☐ | ☐ | ☐ | ☐ | ☐ |
| | **Self-Care** | **None** | **Mild** | **Moderate** | **Severe** | **Extreme or Cannot do** |
| D3.1 | Washing your whole body? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D3.2 | Getting dressed? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D3.3 | Eating? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D3.4 | Staying by yourself for a few days? | ☐ | ☐ | ☐ | ☐ | ☐ |
| | **Getting Along With People** | **None** | **Mild** | **Moderate** | **Severe** | **Extreme or Cannot do** |
| D4.1 | Dealing with people you do not know | ☐ | ☐ | ☐ | ☐ | ☐ |
| D4.2 | Maintaining a friendship? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D4.3 | Getting along with people who are close to you? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D4.4 | Making new friends? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D4.5 | Sexual activities? | ☐ | ☐ | ☐ | ☐ | ☐ |
| | **Life Activities** | **None** | **Mild** | **Moderate** | **Severe** | **Extreme or Cannot do** |
| D5.1 | Taking care of your household responsibilities? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D5.2 | Doing most important household tasks well? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D5.3 | Getting all the household work done that you needed to do? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D5.4 | Getting your household work done as quickly as needed? | ☐ | ☐ | ☐ | ☐ | ☐ |

Patient Name:_____ Date:_____

**If you work (paid, non-paid, self-employed) or go to school, complete D5.5-D5.8 below. Otherwise, Skip to D6.1.**

| | **Because of your health condition, in the past 30 days, how much difficulty did you have in?** | **None** | **Mild** | **Moderate** | **Severe** | **Extreme or Cannot do** |
|---|---|---|---|---|---|---|
| D5.5 | Your day-to-day work/school? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D5.6 | Doing your most important work/school tasks well? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D5.7 | Getting all the work done that you need to do? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D5.8 | Getting your work done as quickly as needed? | ☐ | ☐ | ☐ | ☐ | ☐ |
| | **Participation in Society: In the Past 30 days:** | **None** | **Mild** | **Moderate** | **Severe** | **Extreme or Cannot do** |
| D6.1 | How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D6.2 | How much of a problem did you have because of barriers or hindrances | ☐ | ☐ | ☐ | ☐ | ☐ |
| D6.3 | How much of a problem did you have living with dignity because of the attitudes and actions of others? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D6.4 | How much time did you spend on your health condition or its consequences? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D6.5 | How much have you been emotionally affected by your health condition? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D6.6 | How much has your health been a drain on the financial resources of you or your family? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D6.7 | How much of a problem did your family have because of your health problems? | ☐ | ☐ | ☐ | ☐ | ☐ |
| D6.8 | How much of a problem did you have in doing things by yourself for relaxation or pleasure? | ☐ | ☐ | ☐ | ☐ | ☐ |
| H1 | Overall, in the past 30 days, how many days were these difficulties present? | **Record Number of Days_____** | | | | |
| H2 | In the past 30 days, how many days were you totally unable to carry out your usual activities or work because of any health condition? | **Record Number of Days_____** | | | | |
| H3 | In the past 30 days, not counting the days that you were totally unable, how many days did you cut back or reduce your usual activities or work because of any health condition? | **Record Number of Days_____** | | | | |

# ALERT®

# Wellness Assessment - Adult

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

Client Name (Last, First)

Date of Birth: (mm/dd/yy) / /

Subscriber ID

Authorization #

Clinician Name (Last, First)

Today's Date: (mm/dd/yy) / /

Clinician ID/Tax ID

Clinician Phone -

State

*MRef* ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

***For questions 1-16, please think about your experience in the past week.***

| **How much did the following problems bother you?** | *Not at All* | *A Little* | *Somewhat* | *A Lot* |
|---|---|---|---|---|
| 1. Nervousness or shakiness | ○ | ○ | ○ | ○ |
| 2. Feeling sad or blue | ○ | ○ | ○ | ○ |
| 3. Feeling hopeless about the future | ○ | ○ | ○ | ○ |
| 4. Feeling everything is an effort | ○ | ○ | ○ | ○ |
| 5. Feeling no interest in things | ○ | ○ | ○ | ○ |
| 6. Your heart pounding or racing | ○ | ○ | ○ | ○ |
| 7. Trouble sleeping | ○ | ○ | ○ | ○ |
| 8. Feeling fearful or afraid | ○ | ○ | ○ | ○ |
| 9. Difficulty at home | ○ | ○ | ○ | ○ |
| 10. Difficulty socially | ○ | ○ | ○ | ○ |
| 11. Difficulty at work or school | ○ | ○ | ○ | ○ |

| **How much do you agree with the following?** | *Strongly Agree* | *Agree* | *Disagree* | *Strongly Disagree* |
|---|---|---|---|---|
| 12. I feel good about myself | ○ | ○ | ○ | ○ |
| 13. I can deal with my problems | ○ | ○ | ○ | ○ |
| 14. I am able to accomplish the things I want | ○ | ○ | ○ | ○ |
| 15. I have friends or family that I can count on for help | ○ | ○ | ○ | ○ |

16. In the past week, approximately how many drinks of alcohol did you have? ☐☐ Drinks

**Please answer the following questions only if this is your first time completing this questionnaire.**

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
18. Please indicate if you have a serious or chronic medical condition:
    ○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* ☐☐ Days
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if employed)* ☐☐ Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No