RESTORATIVE THERAPY & WELLNESS LLC

We restore your movement

Shortness-Of-Breath Questionnaire

Name: ______________________________________ **Date:** ___________

Please rate the breathlessness that you experience when you do, or if you were to do, each of the following tasks. **Please do not skip any items**. If you've never performed a task, or no longer perform it, give your best estimate of the breathlessness you would experience while doing that activity.

0	None at all
1	Very light shortness of breath
2	Somewhat shortness of breath
3	Very heavy shortness of breath
4	Severe
5	Maximal or unable to do because of breathlessness

When I do, or if I were to do, the following tasks, I would rate my breathlessness as:

1. At Rest	0	1	2	3	4	5
2. Walking on a level at your own pace	0	1	2	3	4	5
3. Walking on a level with others your age	0	1	2	3	4	5
4. Walking up hill	0	1	2	3	4	5
5. Walking up stairs	0	1	2	3	4	5
6. While eating	0	1	2	3	4	5
7. Standing up from a chair	0	1	2	3	4	5
8. Brushing teeth	0	1	2	3	4	5
9. Shaving and/or brushing hair	0	1	2	3	4	5
10. Showering/Bathing	0	1	2	3	4	5
11. Dressing	0	1	2	3	4	5
12. Picking up and straightening	0	1	2	3	4	5
13. Doing dishes	0	1	2	3	4	5
14. Sweeping/vacuuming	0	1	2	3	4	5
15. Making bed	0	1	2	3	4	5
16. Shopping	0	1	2	3	4	5
17. Doing laundry	0	1	2	3	4	5
18. Washing car	0	1	2	3	4	5
19. Mowing lawn	0	1	2	3	4	5
20. Watering lawn	0	1	2	3	4	5
21. Sexual activities	0	1	2	3	4	5

How much do these limit you in your daily life?

22. Shortness of breath	0	1	2	3	4	5
23. Fear of "hurting myself" by overexerting	0	1	2	3	4	5
24. Fear of shortness of breath	0	1	2	3	4	5

Average Shortness of Breath: ___________________________

Therapist Signature: ____

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