











CONSENT

Test Patient



#### CONSENT TO QUALITY DEVELOPMENT AND RESEARCH

We want your consent to use your information from this questionnaire, and to pass on information from your patient record to:

#### The National Quality and Research Database for People with a Functional Disorder (FunkData)

The 5 centers in Denmark (Center for Functional Disorders, Region of Southern Denmark; Functional Disorders, Central Denmark Region; Center for Functional Disorders, Region Zealand and Center for Complex Symptoms, Capital Region of Denmark) work together to improve the future treatment through the establishment of a quality and research database, which will form the basis for specific quality development projects and research projects within research and treatment.

We therefore ask for your permission to use the information you enter in the questionnaire via www.symptomskema.dk for this purpose.

We will also ask for your consent for the following information to be passed on from your patient record, from the center to which you are referred, to the Quality and Research Database:

- Clinical examination
- Diagnosis
- Medicine
- Treatment

#### **Data Processing**

All information is confidential and subject to professional secrecy. Information from the database can only be used in research projects within the same purpose as described above, which have the formal approvals of public authorities. In addition, the information can be used for specific quality development projects, which are carried out locally in the centers, which are part of this collaboration.

How we use your information: The information is processed in accordance with the Data Protection Regulation art. 6 pieces. 1, letter a and art. 9, para. 2, letter a, which are the rules on consent.

<u>Deleting and storing your data:</u> We will delete or anonymize data when it is no longer relevant to store your personal information.

<u>Please note:</u> Information from the questionnaire is used in your course of treatment in the center and is not passed on to others. If you wish, you have the right to see the information collected from the questionnaire and the right to have any wrong information corrected. You also have the right to have the processing of your information restricted and to complain to the Danish Data Protection Agency about the processing of your information. If you want to see the information collected about you, have it corrected or use your right to limit the processing of your information in connection with your treatment process, please contact Center for Functional Disorders, Region of Southern Denmark who is the database manager on telephone 65413869.

#### Additional Information

The processing and storage of personal data takes place in accordance with the Data Protection Ordinance and the Data Protection Act. If you have questions about the Region of Southern Denmarks processing of your information, you are always welcome to contact the Region of Southern Denmarks data protection adviser via your digital mailbox (borgerdk or e-boks.dk). You can also send an e-mail to databeskyttelsesraadgiver@rsyd.dk. Questions about the database should be directed to Henrik Bjarke Vægter (responsible for the database) or the chief physician at the Center for Functional Disorders, Region of Southern Denmark

The Center for Functional Disorders, Odense University Hospital is responsible for the database, which has been approved by the Danish Data Protection Agency. Database manager: Henrik Bjarke Vægter, Pain Center South / Center for Functional Disorders, Odense University Hospital

Whether you give us your permission or not, it will not affect your course of treatment at the center. If you regret having given your permission, you can revoke your consent at any time via www.symptomskema.dk og by contacting Center for Functional Disorders, Odense University Hospital on telephone 65 41 38 69. The collection of data about you for use in quality assurance and research will then cease.

#### **Participant Statement**

I hereby confirm that I have received sufficient information about the content, purpose, method of the database, including what types of information are passed on from my patient record to the database, as well as what this information is to be used for and how it is processed. I know that participation is voluntary and that I can always withdraw my consent without losing my current or future rights to treatment.

The consent ceases no later than one year after it has been submitted, after which you will again be asked if you want to give your consent to the transfer of your information for use in the database. The fact that a consent is ceased or not desired to be extended does not mean that already passed on information must be deleted from the database.

I hereby give my consent for the answers I have given in the questionnaires to be passed on to the quality and research database.

I hereby give my consent for the above information from my patient record to be passed on for use in the database.

No Yes

I hereby give my consent for the center to which I am referred, to contact me in relation to future projects where my participation may be relevant to me.

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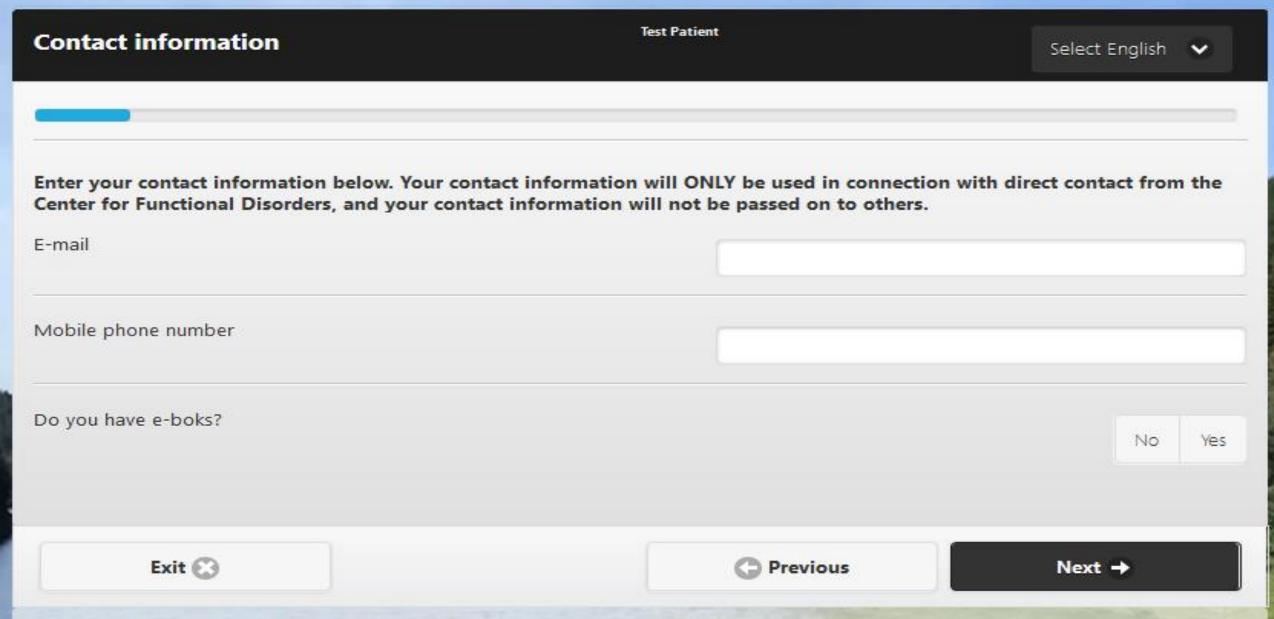






















### Physical symptoms from heart and lungs

**Test Patient** 



On the following pages, we want information on the extent to which you have been bothered by various symptoms.

#### <u>During the last 4 weeks</u>, have you been bothered by:

Palpitations or heart pounding?	Not at all	A bit	Somewhat	Quite a bit	A lot
Precordial discomfort?	Not at all	A bit	Somewhat	Quite a bit	A lot
Breathlessness without exertion?	Not at all	A bit	Somewhat	Quite a bit	A lot
Hyperventilation?	Not at all	A bit	Somewhat	Quite a bit	A lot
Hot or cold sweats?	Not at all	A bit	Somewhat	Quite a bit	A lot
Dry mouth?	Not at all	A bit	Somewhat	Quite a bit	A lot

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### Physical symptoms from stomach and intestines

**Test Patient** 

Select English 🗸

During the last 4 weeks, have you been bothered by:					
Frequent loose bowel movements?	Not at all	A bit	Somewhat	Quite a bit	A lot
Abdominal pains?	Not at all	A bit	Somewhat	Quite a bit	A lot
Feeling bloated/full of gas/distended?					
	Not at all	A bit	Somewhat	Quite a bit	A lot
Diarrhoea?	Not at all	A bit	Somewhat	Quite a bit	A lot
Regurgitations?	Not at all	A bit	Somewhat	Quite a bit	A lot
Nausea?					
ivausea:	Not at all	A bit	Somewhat	Quite a bit	A lot
Burning sensation of the chest or upper part of stomach/epigastrium?	Not at all	A bit	Somewhat	Quite a bit	A lot

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### Physical symptoms from muscles and joints

**Test Patient** 

Select English 🗸

During the last 4 weeks, have you been bothered by:					
Pains in arms or legs?	Not at all	A bit	Somewhat	Quite a bit	A lot
Muscular aches or pains?					
	Not at all	A bit	Somewhat	Quite a bit	A lot
Pains in the joints?					
	Not at all	A bit	Somewhat	Quite a bit	A lot
Section of managinary to relieve described and a					
Feeling of paresis or localised weakness?	Not at all	A bit	Somewhat	Quite a bit	A lot
Backache?	Not at all	A bit	Somewhat	Quite a bit	A lot
Pain moving from one place to another?	Not at all	A bit	Somewhat	Quite a bit	A lot
Unpleasant numbness or tingling sensations?	Not at all	A bit	Somewhat	Quite a bit	A lot

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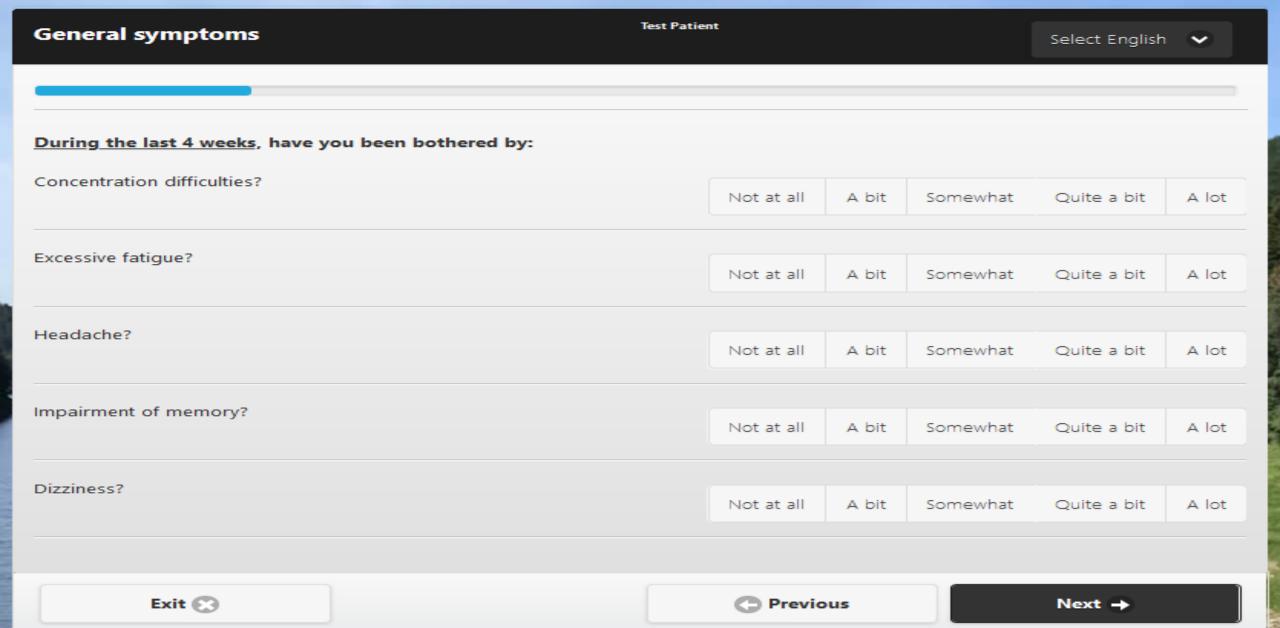






















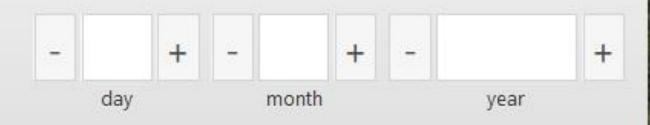


Test Patient

Select English 🔻

Here we want information about how long (approximately) you have experienced your symptoms. Press + or - next to day, month or year to activate the calendar. Then indicate when your symptoms started using the + or - symbols.

Approximately when was the onset of your symptoms?



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# Symptom intensity and interference

Test Patient

Select English 💙

On this page we want information about the intensity of your symptoms, as well as how much your symptoms affect your daily activities.

During the last 7 days, the overall intensity of my symptoms was:

No symptoms at all Worst possible symptoms

During the last 7 days, my bodily symptoms interfered with daily life activities:

Not at all

Interfered completely

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# Test Patient Symptom interference Select English 🗸 On this page we want information about the extent to which your symptoms interfere with your work/daily tasks, your social life/leisure activities and your family life/home responsibilities. Check ONE box for each question. All responses should refer to the last 14 days. Not at all Extremely WORK / DAILY TASKS: The symptoms have disrupted your work / daily tasks Not at all Extremely SOCIAL LIFE: The symptoms have disrupted your social life / leisure activities 10 Not at all Extremely FAMILIY LIFE / HOME RESPONSIBILITIES: The symptoms have 10 disrupted your family life / home responsibilities

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General health	it		Select	t English	•
The following questions are about your perception of your general heal you are feeling and how well you are able to perform your daily tasks a		n will provid	e an over	view of	how
In general, would you say your health is:	Excelle	Very ent Good	Good	Fair	Poor
Compared to one year ago, how would you rate your health in general now	?:				
Much better now than one year ago					
Somewhat better now than one year ago					
About the same					
Somewhat worse now than one year ago					
Much worse than one year ago					
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Yes, Limited

a Lot

Yes, Limited

a Little

No, Not

Limited at all



### Limitations of activities

Bending, kneeling, or stooping

Test Patient

Select English 🗸

Yes, Limited	Yes, Limited	No, Not
a Lot	a Little	Limited at all
Yes, Limited	Yes, Limited	No, Not
a Lot	a Little	Limited at all
Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at all
Yes, Limited	Yes, Limited	No, Not
a Lot	a Little	Limited at all
Yes, Limited	Yes, Limited	No, Not
a Lot	a Little	Limited at all
	Yes, Limited a Lot  Yes, Limited a Lot  Yes, Limited a Lot  Yes, Limited a Lot	Yes, Limited a Little  Yes, Limited a Little

Nazalliča a na ana Alama a Lölanaskan				
Walking more than a kilometer	Yes, Li a L	mited ot	Yes, Limited a Little	No, Not Limited at all
NATION LAND I				
Walking several 100 meters	Yes, Li a L	mited ot	Yes, Limited a Little	No, Not Limited at all
Walking 100 meter				
Walking 100 meter	Yes, Li a L		Yes, Limited a Little	No, Not Limited at all
Bathing or dressing yourself	Yes, Li a L		Yes, Limited a Little	No, Not Limited at all
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# Physical health problems

**Test Patient** 

Select English 🗸

<u>During the past 4 weeks</u> , have you had any of the following of <u>your physical health?</u>	problems with yo	our work or	other regula	r daily activitie	es as a resul
Cut down the amount of time you spent on work or other					
activities	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time
Accomplished less than you would like	All of	Most of	Some of	A little bit	None of
	the time	the time	the time	of the time	the time
Were limited in the kind of work or other activities	All of	Most of	Some of	A little bit	None of
	the time	the time	the time	of the time	the time
Had difficulty performing the work or other activities (for					
example, it took extra effort)	All of	Most of	Some of	A little bit	None of

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the time

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the time

the time

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the time

of the time











# **Emotional health problems**

**Test Patient** 

Select English 🗸

<u>During the past 4 weeks</u> , have you had any of the following problems with your work or other regular daily activities as a resu	lt
of any <u>emotional problems</u> ( <u>such as feeling depressed or anxious</u> )?	

Cut down t	the	amount	of	time	you	spent	on	work or	other
activities									

All of	Most of	Some of	A little bit	None of
the time	the time	the time	of the time	the time

#### Accomplished less than you would like

All of	Most of	Some of	A little bit	None of
the time	the time	the time	of the time	the time

Didnt do work or other activities as carefully as usual

All of	Most of	Some of	A little bit	None of
the time	the time	the time	of the time	the time

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**Test Patient** 

Select English

<u>During the last 4 weeks</u>, emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all

Slightly

Moderately

Severely

Very Severely

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Pain	Test Patient			Selec	ct English	•
How much bodily pain have you had during the past 4 weeks? :						
None						
Very Mild						
Mild						
Moderate						
Severe						
Very Severe						
During the past 4 weeks how much did pain interfers with						
<u>During the past 4 weeks</u> , how much did pain interfere with your normal work (including both work outside the home	Not at all	Slightly	Moderately	Severely	Very Se	verely
and housework)?						
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# **Energy and emotions**

Test Patient

Select English 💌

These questions are about how you feel and how things he give the answer that comes closest to the way you have be		during <u>the la</u>	st 4 weeks.	For each quest	ion, please
Did you feel full of pep?	All of	Most of	Some of	A little bit	None of
	the time	the time	the time	of the time	the time
Have you been a very nervous person?					
	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time
Have you felt so down in the dumps that nothing could					
cheer you up?	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time
Have you felt calm and peaceful?	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time
Did you have a lot of energy?					

Have you felt downhearted and blue?						
riave you reit downnearted and blue:	All of	Most of	Some of	A little bit	None of	
	the time	the time	the time	of the time	the time	
Did you feel worn out?				A 1911 L 1		
	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time	
	the time	ine iime	the time	or the time	the time	
Have you been a happy person?						
riave you been a happy person:	All of	Most of	Some of	A little bit	None of	
	the time	the time	the time	of the time	the time	
Did you feel tired?	All -E	1446	C	A 1:441 - L:4	Name of	
	All of the time	Most of the time	Some of the time	A little bit of the time	None of the time	
	the time	the time	the time	or the time	the time	
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					,	













**Test Patient** 

Select English

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

All of Most of Some of A little bit None of the time the time the time of the time the time

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### **General health**

**Test Patient** 

Select English 🗸



How true or false is each of the following statements for you?								
I seem to get sick a little easier than other people	Definitely true	Mostly true	Do not know	Mostly false	Definitely false			
I am as healthy as anybody I know	Definitely true	Mostly true	Do not know	Mostly false	Definitely false			
expect my health to get worse	Definitely true	Mostly true	Do not know	Mostly false	Definitely false			
My health is excellent	Definitely	Mostly	Do not	Mostly	Definitely			

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true

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true

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false

false

know



On this page, we want information on the extent to which	you during the last 4 weeks have been bothered by:
On this page, we want information on the extent to which	you during the last 4 weeks, have been bothered by.

Worries that there is something seriously wrong with y	our
body?	

N	A 1201 1 20			
Not at all	A little bit	Moderately	Quite a bit	A great deal

Worries that you suffer a disease you have read or heard about?

Not at all A little bit Moderately Quite a bit A great deal

Worries about the possibility of having a serious illness?

Not at all A little bit Moderately Quite a bit A great deal

Thoughts, that the doctor may be wrong if telling you not to worry?

Not at all A little bit Moderately Quite a bit A great deal

Worries about your health?

Not at all A little bit Moderately Quite a bit A great deal

Recurrent thoughts about being ill that are difficult to get off your mind?

Not at all A little bit Moderately Quite a bit A great deal





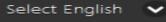






### Symptoms of anxiety and depression

Test Patient



#### On the next pages, we want information on the extent to which you during the last 4 weeks, have been bothered by the following:

Feeling suddenly scared for no reason?	Not at all	A little bit	Moderately	Quite a bit	A great deal
Namenuanas or shakinass insida?					
Nervousness or shakiness inside?	Not at all	A little bit	Moderately	Quite a bit	A great deal
Spells of terror or panic?	Not at all	A little bit	Moderately	Quite a bit	A great deal
You worry too much?	Not at all	A little bit	Moderately	Quite a bit	A great deal
Feeling fearful?	Not at all	A little bit	Moderately	Quite a bit	A great deal

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# Symptoms of anxiety and depression

**Test Patient** 

Select English

<u>During the last 4 weeks</u> , have you been bothered	by:				
Feeling hopeless about the future?					
	Not at all	A little bit	Moderately	Quite a bit	A great deal
Feeling everything is an effort?					
	Not at all	A little bit	Moderately	Quite a bit	A great deal
Feeling blue?					
recing blue.	Not at all	A little bit	Moderately	Quite a bit	A great deal
Englings of worthloseness?					
Feelings of worthlessness?	Not at all	A little bit	Moderately	Quite a bit	A great deal
The combine of an dimension life?					
Thoughts of ending your life?	Not at all	A little bit	Moderately	Quite a bit	A great deal

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Blaming yourself for things?	Not at all	A little bit	Moderately	y Quite a bit A great d	
pl : If f ull: a					
Feeling lonely?	Not at all	A little bit	Moderately	Quite a bit	A great deal
Feelings of being trapped or caught?	Not at all	A little bit	Moderately	Quite a bit	A great deal
Facilities of hairman and an assumbto					











### Thoughts about your symptoms

Test Patient



On the next pages, we want information about your thoughts and experiences related to your symptoms.

For each question, please choose the number between 0 and 10 that best matches your thoughts and experiences at the moment.

	No affect at all					Severely affects my life			
How much do your symptoms affect your life?	0 1	2 3	4	5	6	7	8	9	10
	A very short to	time						F	orever
How long do you think your symptoms will continue?	0 1	2 3	4	5	6	7	8	9	10
	Absolutely no	contro	I		Ext	reme	amou	nt of	control
How much control do you feel you have over your symptoms?		contro		5		reme 7		nt of	control 10
				5			8	9	

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### Thoughts about your symptoms

Test Patient



For each question, please choose the number between 0 and 10 that best matches your thoughts and experiences at the moment.

Not at all concerned Extremely concerned How concerned are you about your symptoms? Understand very clearly Do not understand at all How well do you feel you understand your symptoms? Not at all affected Extremely affected How much do your symptoms affect you emotionally? (e.g. do they make you angry, scared, upset or depressed?) Not likely at all Extremely likely How likely do you think it is that you will 10 recover completely?

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# Test Patient Thoughts about your symptoms Select English 💙 Would you describe your problem as: : Physical illness alone Mental distress Both physically and mentally Other things Yes, very clearly No, not at all I know exactly what is wrong with me 4 5

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Thoughts about your symptoms	Test Patient	Select English 🗸
Please list in rank-order the three most imp	portant factors that you believe caused your sympto	oms.
1st cause		
2nd cause		
3rd cause		
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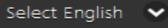






# Behavioural responses to your symptoms

Test Patient



On the following pages, we want information on how to manage your symptoms.

The statements below are about things you may or may not have done to manage your symptoms. Indicate how often you have done the following <u>during the last 4 weeks</u>.

I have	avoided	physical	OVORCICO
I Have	avolueu	DITYSICAL	exel dise

Not		Some	Most	Every
at all	Rarely	days	days	day

I have overdone things, then needed to rest up for a while

Not		Some	Most	Every
at all	Rarely	days	days	day

I have put parts of my life on hold

Not		Some	Most	Every
at all	Rarely	days	days	day

I have pushed myself as hard as ever until I can not push	Not	Rarely	Some	Most	Every
myself any more	at all		days	days	day
I have avoided my usual activities	Not at all	Rarely	Some days	Most days	Every day
I have carried on with things as normal until my body can	Not	Rarely	Some	Most	Every
not cope any longer	at all		days	days	day
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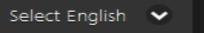






# Behavioural responses to your symptoms

Test Patient



On the following pages, we want information on how to manage your symptoms.

The statements below are about things you may or may not have done to manage your symptoms. Indicate how often you have done the following <u>during the last 4 weeks</u>.

I have gone to bed during the day

Not		Some	Most	Every
at all	Rarely	days	days	day

I have felt obliged to carry out all my responsibilities, no matter how bad I feel

Not		Some	Most	Every
at all	Rarely	days	days	day

I have tried to do too much and felt even worse as a result

Not		Some	Most	Every
at all	Rarely	days	days	day

Not	Rarely	Some	Most	Every
at all		days	days	day
Not at	Rarely	Some	Most	Every
all		days	days	day
Not	Rarely	Some	Most	Every
at all		days	days	day
Not	Rarely	Some	Most	Every
at all		days	days	day
		N		
	Not at all  Not at all	Not at all Rarely  Not at all Rarely  Not at all Rarely	Not at all Rarely days  Not at all Rarely days  Not at all Rarely days  Not at all Rarely days	Not at all Rarely days days  Not at all Rarely Some days  Not at all Rarely days days  Not at all Rarely days days  Not at all Rarely days days

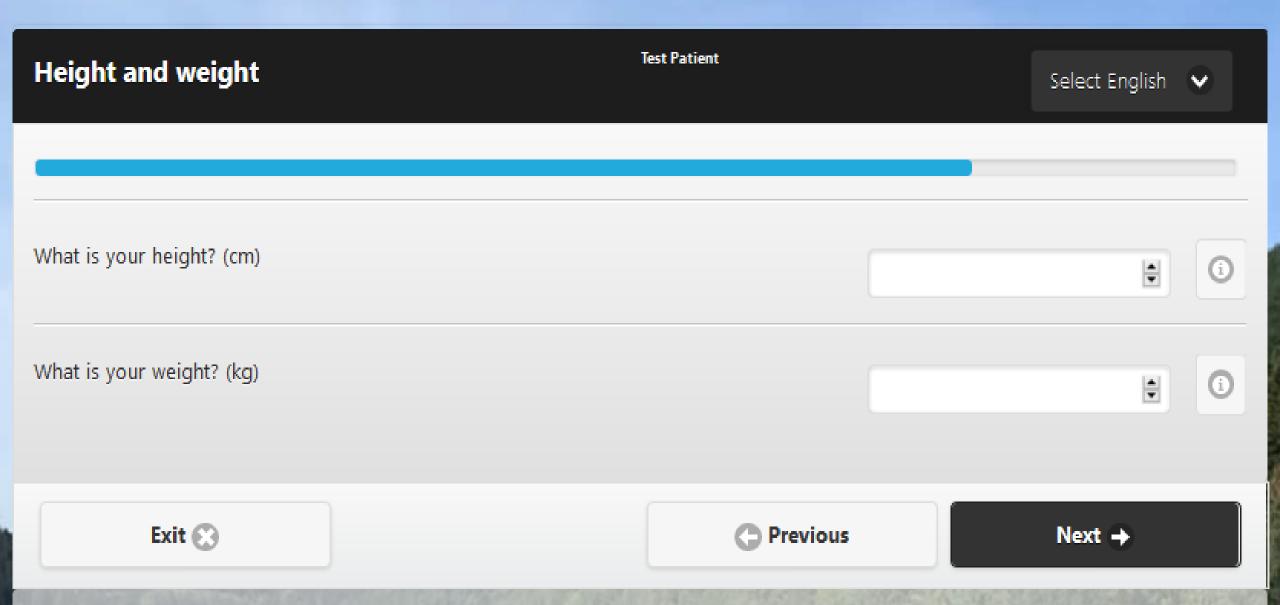












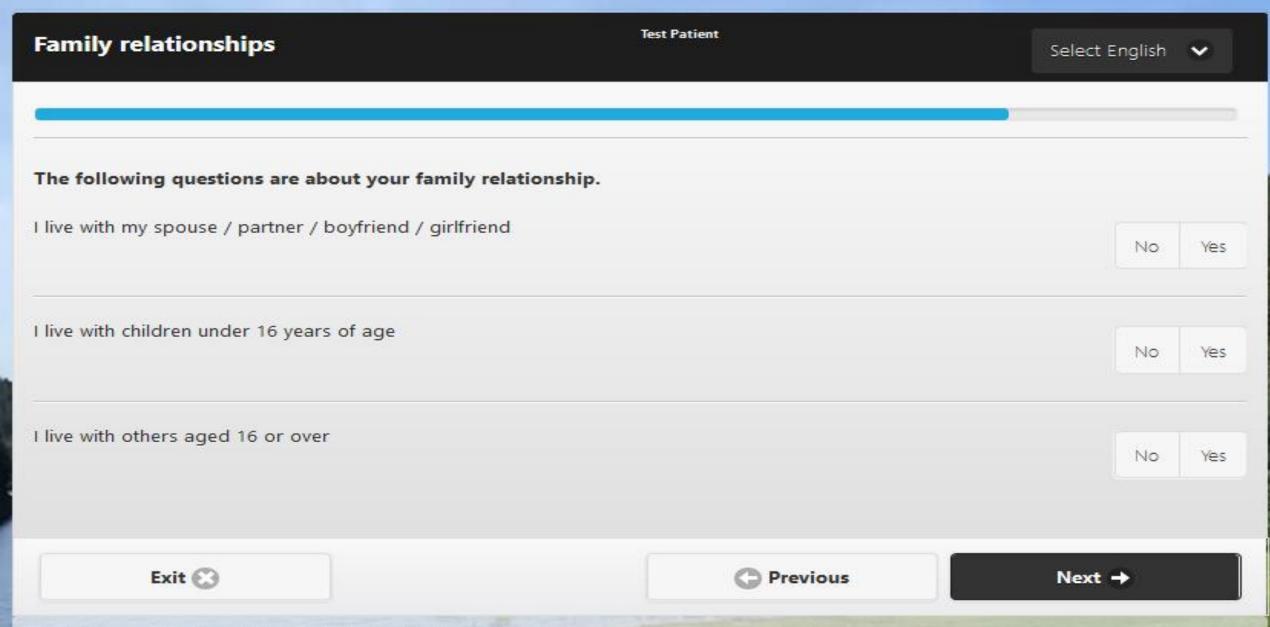












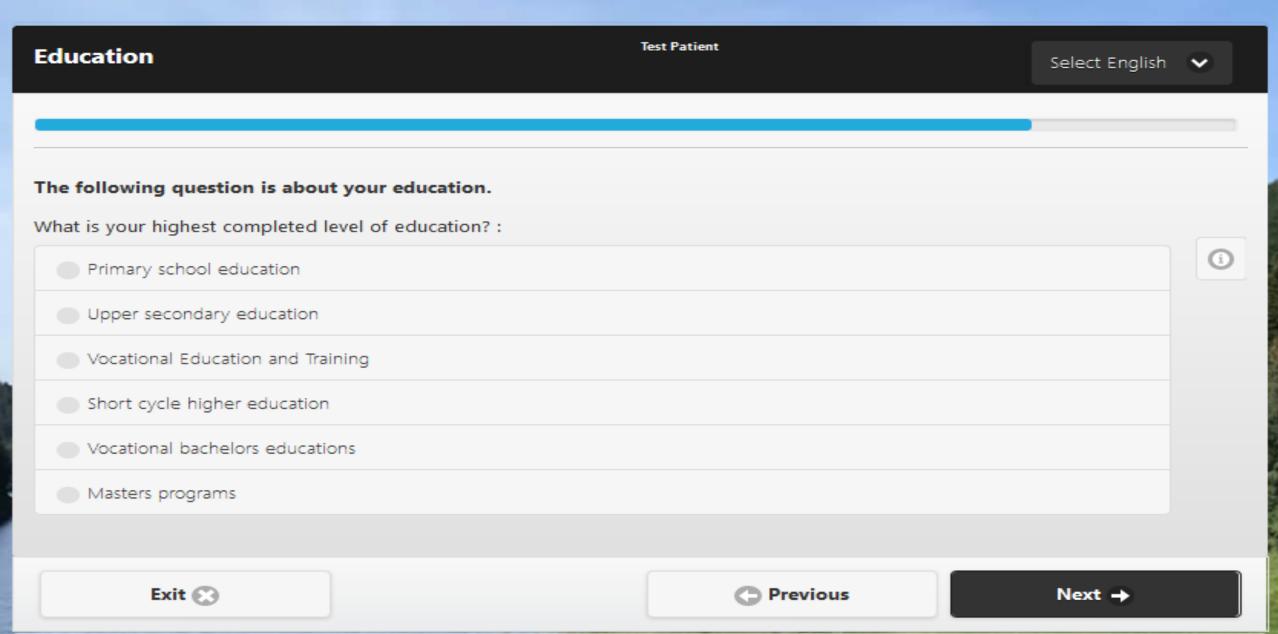






















### **Working life**

Test Patient

Select English 💟

#### The following questions are about your work life.

Which statement best suits your current work situation?:

- Working
- Part-time sick leave
- Full-time sick leave
- Unemployed
- Subsidised job
- Sick leave from subsidised job
- Disability pension
- Pension
- Student
- Other type of public support

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How many years have you been in the labor market (including periods where you have been on sick leave from your job)?



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