JUVENILE ARTHRITIS MULTIDIMENSIONAL ASSESSMENT REPORT (JAMAR)

English translation **Child's version**

Patient's name and surname (or initials):_____ Date:_____

The aim of this questionnaire is to gather information on the current state of your illness.
Your answers will help us improve our clinical evaluation.
Please read the questions below carefully and choose the answers that best apply to you.
If you have doubts or need any clarification, please ask for our help.
There are no right or wrong answers.
We simply ask that you answer exactly as you feel.

1. Evaluation of functional ability

Please choose the answer that best describes your ability to carry out the activities listed below during the **past four weeks**.
Please indicate only the difficulties or limitations **caused by the illness**.

	With NO difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
1. Run on flat ground for at least 10 metres	☐	☐	☐	☐
2. Walk up 5 steps	☐	☐	☐	☐
3. Jump forward	☐	☐	☐	☐
4. Squat	☐	☐	☐	☐
5. Bend down to pick up an object off the floor	☐	☐	☐	☐
6. Carry out activities that require the use of your fingers	☐	☐	☐	☐
7. Open and close your fists	☐	☐	☐	☐
8. Squeeze an object with your hands	☐	☐	☐	☐
9. Open a door by lowering the handle	☐	☐	☐	☐
10. Open and close a tap or open a previously opened jar	☐	☐	☐	☐
11. Stretch out your arms	☐	☐	☐	☐
12. Put your hands behind your neck	☐	☐	☐	☐
13. Turn your head and look over your shoulders	☐	☐	☐	☐
14. Bend your head back and look at the ceiling	☐	☐	☐	☐
15. Bite into a sandwich or an apple	☐	☐	☐	☐

2. How much pain have you had because of the illness over the past week?
(choose the most accurate score)

NO PAIN **EXTREME PAIN**

○ ○

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

PATIENT ID_____ **DATE OF VISIT (DD/MM/YYYY)**_____

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3. Please indicate if <u>today</u> you are feeling <u>pain</u> or have <u>swelling</u> in any of the joints listed below

LEFT SIDE	Presence of pain or swelling	RIGHT SIDE	Presence of pain or swelling
Fingers	☐	Fingers	☐
Wrist	☐	Wrist	☐
Elbow	☐	Elbow	☐
Shoulder	☐	Shoulder	☐
Hip	☐	Hip	☐
Knee	☐	Knee	☐
Ankle	☐	Ankle	☐
Toes	☐	Toes	☐
	Neck	☐	
	Lower back	☐	
I have no joints with pain or swelling		☐	

4. Have you had <u>joint stiffness</u> upon waking up <u>over the past week</u>? Yes ☐ No ☐

If you answered "yes", how long does it last?

15 minutes or less	15 to 30 minutes	30 minutes to 1 hour	1 to 2 hours	More than 2 hours
☐	☐	☐	☐	☐

5. Please indicate if you have had either or both of the symptoms listed below <u>over the past week</u>

Fever higher than 38°C (if due to arthritis) Yes ☐ No ☐

Skin rash (if due to arthritis) Yes ☐ No ☐

6. Considering all the symptoms, such as pain, joint swelling, morning stiffness, fever (if due to arthritis), and skin rash (if due to arthritis), please evaluate the <u>level of activity</u> of your illness <u>at the moment</u> (choose the most accurate score)

NO ACTIVITY — **MAXIMUM ACTIVITY**

○ ○

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

7. How would you evaluate the <u>current state</u> of your illness?

Complete absence of symptoms (**remission**)	Continuing presence of symptoms (**persistent activity**)	Recurrence of symptoms after a period of complete well-being (**relapse**)
☐	☐	☐

8. Compared to your last visit, how would you evaluate the <u>course</u> of your illness?

Much improved	Slightly improved	Stable/unchanged	Slightly worsened	Much worsened
☐	☐	☐	☐	☐

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9. Are you taking any medication to treat arthritis? Yes ☐ No ☐

If you answered "no", please go directly to question 13
If "yes", please also answer questions 10, 11, and 12

10. Which medication are you currently taking?

NSAIDs (e.g._____) ☐ Please specify_____			
Steroids (e.g._____) ☐ Please specify_____			
Methotrexate (e.g._____) ☐ *Oral* ☐ *Subcutaneous* ☐ *Intramuscular* ☐			
Salazopyrin (e.g. _____) ☐		Cyclosporine (e.g. _____) ☐	
Etanercept (Enbrel) ☐	Infliximab (Remicade) ☐	Adalimumab (Humira) ☐	
Golimumab (Simponi) ☐	Certolizumab (Cimzia) ☐	Abatacept (Orencia) ☐	
Anakinra (Kineret) ☐	Canakinumab (Ilaris) ☐	Rilonacept (Arcalyst) ☐	
Tocilizumab (Actemra) ☐	Other (please specify_____) ☐		
Other (please specify _____) ☐	Other (please specify_____) ☐		

11. Since your last visit, have you had any disturbances which may be caused by the medication you are taking? Yes ☐ No ☐

If you answered "yes", please specify which in the table below

Fever	☐	Pain or burning feeling in the stomach	☐
Headache	☐	Nausea	☐
Skin rash	☐	Vomiting	☐
Mouth sores	☐	Constipation	☐
Swollen/bleeding gums	☐	Diarrhoea	☐
Increased body hair	☐	Black or bloody stools	☐
Weight gain	☐	Blood in the urine	☐
Weight loss	☐	Swelling, bruising, pain, redness, etc., at the injection site	☐
Mood swings (excitement, depression, anxiety)	☐	Other (please describe)_____	☐
Sleep disturbances	☐	Other (please describe)_____	☐

12. Do you take your medication regularly (as prescribed by the doctor) at home? Yes ☐ No ☐

If "no", why not?

I refuse to	☐	Too many administrations during the day	☐
Organisational difficulty (for example, problems taking medication at school)	☐	Fear of side effects	☐
I take too much medication	☐	Other (please specify) _____	☐

Which medication is most difficult to take on a regular basis? _____

13. Do you attend school? Yes ☐ No ☐

If you answered "yes", what school-related problems does the illness cause?

None	☐	Difficulty in my relationships with teachers	☐
Numerous absences	☐	Decrease in performance	☐
Difficulty in remaining seated for a long time	☐	Other (please specify) _____	☐

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14. Evaluation of Quality of Life

Please choose the answer that best describes your overall health.

Considering the **<u>past four weeks</u>**, we would like to know if you:

	Never	Some-times	Often	Every day
1. Have had any difficulty taking care of you, for example eating, getting dressed or washing	☐	☐	☐	☐
2. Have had any difficulty taking a 15 minute walk or walking up a flight of stairs	☐	☐	☐	☐
3. Have had any difficulty carrying out activities that require a lot of energy such as running, playing football, dancing etc.	☐	☐	☐	☐
4. Have had any difficulty doing at-school activities or playing with friends	☐	☐	☐	☐
5. Have had any pain	☐	☐	☐	☐
6. Have felt sad or depressed	☐	☐	☐	☐
7. Have felt nervous or anxious	☐	☐	☐	☐
8. Have had any trouble getting along with other children	☐	☐	☐	☐
9. Have had any difficulty concentrating or paying attention	☐	☐	☐	☐
10. Have felt dissatisfied with your physical appearance or abilities	☐	☐	☐	☐

15. Considering all the ways the illness affects you, please evaluate how you feel <u>at the moment</u> (choose the most accurate score)

VERY WELL ○ **VERY POORLY**

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

16. Considering all the ways the illness affects you, would you be satisfied if your condition remained stable/unchanged <u>for the next few months</u>?

Yes ☐	No ☐

Thank you very much for having taken the time to fill in this questionnaire.

The information you have provided will be very useful for following the changes in the course of your illness in the best possible way.

The information in this questionnaire will be kept strictly confidential and will be used only for clinical or research activities.

All data will be handled anonymously.

Please indicate if you authorise or do not authorise the use of the information in this questionnaire for scientific purposes.

I authorise ☐ **I do not authorise** ☐

Patient's name and surname or initials (please print)_____

Signature: _____