Trials Directories
Complete List
Ongoing Trials
Completed Trials
Acute Stroke Trials
Hemorrhage Trials
Prevention Trials
Recovery Trials
Interventions
Drugs - By Name
Drugs - By Category
Procedures
Recovery Therapies
Assessment Scales
Specific Stroke Scales
Stroke Scale Links
Stroke Scales Overview
Stroke Trial Links
Government Sites
Independent Sites
News & Updates
Recent Updates
Update List
General Stroke News

About this Site
List Your Trial
Send Feedback

Search for Trials
GO

PubMed
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Washington University in St. Louis
School of Medicine

Stroke Scales & Clinical Assessment Tools

Stroke Specific Quality of Life Scale (SS-QOL)

Scoring: each item shall be scored with the following key

Total help - Couldn't do it at all - Strongly agree	1
A lot of help - A lot of trouble - Moderately agree	2
Some help - Some trouble - Neither agree nor disagree	3
A little help - A little trouble - Moderately disagree	4
No help needed - No trouble at all - Strongly disagree	5

ITEM	SCORE
Energy	___
1. I felt tired most of the time.	___
2. I had to stop and rest during the day.	___
3. I was too tired to do what I wanted to do.	___
Family Roles	
1. I didn't join in activities just for fun with my family.	___
2. I felt I was a burden to my family.	___
3. My physical condition interfered with my personal life.	___
Language	
1. Did you have trouble speaking? For example, get stuck, stutter, stammer, or slur your words?	___
2. Did you have trouble speaking clearly enough to use the telephone?	___
3. Did other people have trouble in understanding what you said?	___
4. Did you have trouble finding the word you wanted to say?	___
5. Did you have to repeat yourself so others could understand you?	___
Mobility	
1. Did you have trouble walking? (If patient can't walk, go to question 4 and score questions 2-3 as 1.)	___
2. Did you lose your balance when bending over to or reaching	

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for something? ___

3. Did you have trouble climbing stairs? ___

4. Did you have to stop and rest more than you would like when walking or using a wheelchair? ___

5. Did you have trouble with standing? ___

6. Did you have trouble getting out of a chair? ___

Mood

1. I was discouraged about my future. ___

2. I wasn't interested in other people or activities. ___

3. I felt withdrawn from other people. ___

4. I had little confidence in myself. ___

5. I was not interested in food. ___

Personality

1. I was irritable. ___

2. I was inpatient with others. ___

3. My personailty has changed. ___

Self Care

1. Did you need help preparing food? ___

2. Did you need help eating? For example, cutting food or preparing food? ___

3. Did you need help getting dressed? For example, putting on socks or shoes, buttoning buttons, or zipping? ___

4. Did you need help taking a bath or a shower? ___

5. Did you need help to use the toilet? ___

Social Roles

1. I didn't go out as often as I would like. ___

2. I did my hobbies and recreation for shorter periods of time than I would like. ___

3. I didn't see as many of my friends as I would like. ___

4. I had sex less often than I would like. ___

5. My physical condition interfered with my social life. ___

Thinking

1. It was hard for me to concentrate. ___

2. I had trouble remebering things. ___

3. I had to write things down to remember them. ___

Upper Extremity Function

1. Did you have trouble writing or typing? ___

2. Did you have trouble putting on socks? ___

3. Did you have trouble buttoning buttons? ___

4. Did you have trouble zipping a zipper? ___

5. Did you have troouble opening a jar? ___

Vision

1. Did you have trouble seeing the television well enough to enjoy a show? ___
2. Did you have trouble reaching things because of poor eyesight? ___
3. Did you have trouble seeing things off to one side? ___

Work / Productivity

1. Did you have trouble doing daily work around the house? ___
2. Did you have trouble finishing jobs that you started? ___
3. Did you have trouble doing the work you used to do? ___

TOTAL SCORE: ___

Reference

Williams LS, Weinberger M, Harris LE, Clark DO, Biller J. Development of a stroke-s quality of life scale.
Stroke 1999 Jul;30(7):1362-9.
