



January 19, 2006

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Stroke Scales & Clinical Assessment Tools

Stroke Specific Quality of Life Scale (SS-QOL)

Scoring: each item shall be scored with the following key

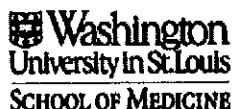
Total help - Couldn't do it at all - Strongly agree	1
A lot of help - A lot of trouble - Moderately agree	2
Some help - Some trouble - Neither agree nor disagree	3
A little help - A little trouble - Moderately disagree	4
No help needed - No trouble at all - Strongly disagree	5

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 I felt withdrawn from other people.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 impatient with others. _____
3. My personality 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 remembering 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 trouble 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.

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