

Appendix 2. Juvenile Arthritis Multidimensional Assessment Report (JAMAR). Child's version.

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

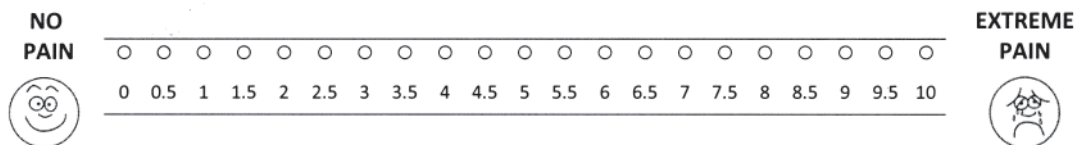
The aim of this questionnaire is to gather information on the current state of your illness. Your answers will help us improve our clinical evaluation. Please read the questions below carefully and choose the answers that best apply to you. If you have doubts or need any clarification, please ask for 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 with particular reference to 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Walk up 5 steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Jump forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Bend down to pick up an object off the floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Carry out activities that require the use of your fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Open and close your fists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Squeeze an object with your hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Open a door by lowering the handle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Open and close a tap or open a previously opened jar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Stretch out your arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Put your hands behind your neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Turn your head and look over your shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Bend your head back and look at the ceiling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Bite into a sandwich or an apple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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



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. _____) <input type="checkbox"/>	Please specify _____		
Steroids (e.g. _____) <input type="checkbox"/>	Please specify _____		
Methotrexate (e.g. _____) <input type="checkbox"/>	Oral <input type="checkbox"/>	Subcutaneous <input type="checkbox"/>	Intramuscular <input type="checkbox"/>
Salazopyrin (e.g. _____) <input type="checkbox"/>	Cyclosporine (e.g. _____) <input type="checkbox"/>		
Etanercept (Enbrel) <input type="checkbox"/>	Infliximab (Remicade) <input type="checkbox"/>	Adalimumab (Humira) <input type="checkbox"/>	
Golimumab (Simponi) <input type="checkbox"/>	Certolizumab (Cimzia) <input type="checkbox"/>	Abatacept (Orencia) <input type="checkbox"/>	
Anakinra (Kineret) <input type="checkbox"/>	Canakinumab (Ilaris) <input type="checkbox"/>	Rilonacept (Arcalyst) <input type="checkbox"/>	
Tocilizumab (Actemra) <input type="checkbox"/>	Other (please specify _____) <input type="checkbox"/>		
Other (please specify _____) <input type="checkbox"/>		Other (please specify _____) <input type="checkbox"/>	

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

12. Do you take your medication regularly (as prescribed by the doctor) at home?

Yes No

If "no", why not?

I refuse to <input type="checkbox"/>	Too many administrations during the day <input type="checkbox"/>
Organisational difficulty (for example, problems taking medication at school) <input type="checkbox"/>	Fear of side effects <input type="checkbox"/>
I take too much medication <input type="checkbox"/>	Other (please specify) _____ <input type="checkbox"/>

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?

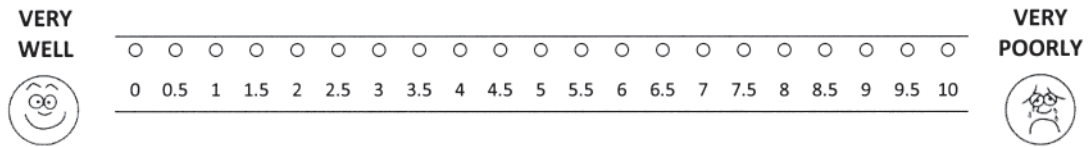
None <input type="checkbox"/>	Difficulty in my relationships with teachers <input type="checkbox"/>
Numerous absences <input type="checkbox"/>	Decrease in performance <input type="checkbox"/>
Difficulty in remaining seated for a long time <input type="checkbox"/>	Other (please specify) _____ <input type="checkbox"/>

14. Evaluation of Quality of Life

Please choose the answer that best describes your overall health.
Considering the **past four weeks**, we would like to know if you:

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

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



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

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.