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**APPENDIX A**

**INDEMNIFICATION**

I, ..... (full name of prospective participant), submit myself herewith to the Sports Research Institute of the University of Pretoria (hereafter referred to as the **UNIVERSITY**), to the services and facilities of the said **UNIVERSITY**, for the purpose of an official research project.

And, whereas I am aware of the fact that it may constitute a potential risk to my health to participate in the research project, I hereby declare that I participate in the said research project at my own risk, and that I hereby totally indemnify the **UNIVERSITY** and all its appointed employees and co-workers.

I hereby declare that there is no information withheld by myself or by the parties listed above that could exclude me from participating in this research project.

I furthermore authorise the **UNIVERSITY** to publish and use any results forthcoming from the research project, and declare that I have no claim to any remuneration or compensation therefrom.

Signed at ..... on this ..... day of ..... 2001

.....  
**Signature of the prospective participant**

Tel: (h) ..... (w) .....  
Code and Number Code and Number Cell

**WITNESSES**

1. ....
2. ....

(University of Pretoria, Institute for Sports Research)

**APPENDIX B**

**STEINBROCKER CRITERIA FOR R.A. CLASSIFICATION**

**CLASSIFICATION OF FUNCTION IMPAIRMENT**

The following classification of functional impairment is recommended as an adjunct to the criteria for the stages of rheumatoid arthritis.

**CLASS 1 :** Complete functional capacity with ability to carry on all usual duties without handicaps.

**CLASS 2 :** Functional capacity adequate to conduct normal activities despite handicap of discomfort or limited mobility of one or more joints.

**CLASS 3 :** Functional capacity adequate to perform only little or none of the duties of usual occupation or self-care.

**CLASS 4 :** Largely or wholly incapacitated with patient bedridden or confined to wheel-chair, permitting little or no self-care.

(Ball & Koopman, 1986)

**APPENDIX C**

<b>NUMBER OF TENDER &amp; SWOLLEN JOINTS</b>						
Was exam performed? <b>No</b> <input type="checkbox"/> (if no, give reason in comments) <b>Yes</b> <input type="checkbox"/>						
Date completed: ..... <b>Day-Month-Year</b>						
Perform exam with patient in <b>SITTING</b> position						
<b>TENDER JOINT SCALE</b> 0 = No pain 1 = Patient states that there is pain 2 = Patient states that there is pain and winces 3 = Patient states that there is pain, winces, and withdraws				<b>SWOLLEN JOINT SCALE:</b> 0 = Absent 1 = Detectable synovial thickening without loss of bony contours 2 = Loss of distinctiveness of bony contours 3 = Bulging synovial proliferation with cystic characteristics		
<b>RIGHT</b>			JOINT LOCATION	<b>LEFT</b>		
Joint Not Evaluable	Tender Joint Score	Swollen Joint Score	Temporomandibular	Joint Not Evaluable	Tender Joint Score	Swollen Joint Score
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Acromioclavicular	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Sternoclavicular	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Shoulder	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Elbow	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Wrist	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	MCP 1 (hand)	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	MCP 2 (hand)	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	MCP 3 (hand)	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	MCP 4 (hand)	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	MCP 5 (hand)	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Thumb IP	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Finger PIP 2	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Finger PIP 3	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Finger PIP 4	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Finger PIP 5	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Finger DIP 2	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Finger DIP 3	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Finger DIP 4	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Finger DIP 5	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<b>COMMENTS:</b>						

Investigator's name:	Investigator's initials:	Date:
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<b>NUMBER OF TENDER &amp; SWOLLEN JOINTS</b>						
Was exam performed? No <input type="checkbox"/> (if no, give reason in comments) Yes <input type="checkbox"/>						
Date completed: ..... (Day-Month-Year)						
Perform exam with patient in <b>SITTING</b> position						
<b>TENDER JOINT SCALE</b> 0 = No pain 1 = Patient states that there is pain 2 = Patient states that there is pain and winces 3 = Patient states that there is pain, winces, and withdraws				<b>SWOLLEN JOINT SCALE:</b> 0 = Absent 1 = Detectable synovial thickening without loss of bony contours 2 = Loss of distinctiveness of bony contours 3 = Bulging synovial proliferation with cystic characteristics		
<b>RIGHT</b>			JOINT LOCATION	<b>LEFT</b>		
Joint Not Evaluable	Tender Joint Score	Swollen Joint Score		Joint Not Evaluable	Tender Joint Score	Swollen Joint Score
<input type="checkbox"/>	0 1 2 3		Hip	<input type="checkbox"/>	0 1 2 3	
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Knee	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Ankle	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Tarsus	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	MTP 1 (Foot)	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	MTP 2 (Foot)	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	MTP 3 (Foot)	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	MTP 4 (Foot)	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	MTP 5 (Foot)	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Great Toe PIP	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Toe PIP/DIP 2	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Toe PIP/DIP 3	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Toe PIP/DIP 4	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<input type="checkbox"/>	0 1 2 3	0 1 2 3	Toe PIP/DIP 5	<input type="checkbox"/>	0 1 2 3	0 1 2 3
<b>GRAND COUNT OF TENDER JOINTS</b>						
(Scores of 1, 2 or 3) <input type="checkbox"/>						
<b>GRAND COUNT OF SWOLLEN JOINTS</b>						
(Scores of 1, 2 or 3) <input type="checkbox"/>						
<b>COMMENTS:</b>						

<b>Investigator's name:</b> (Ritchie et al., 1968)	<b>Investigator's initials:</b>	<b>Date:</b>
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**APPENDIX D**

<b>HEALTH ASSESMENT QUESTIONNAIRE</b>				
Was assessment completed? <b>No</b> <input type="checkbox"/> (If no, give reason in comments) <b>Yes</b> <input type="checkbox"/>				
Date completed: ..... Day/Month/Year				
<b><i>In this section we are interested in learning how your illness affects your ability to function in daily life.</i></b>				
Please tick the response with <b>best describes your usual abilities</b> during the past week:				
	<b>Without ANY Difficulty</b>	<b>With SOME Difficulty</b>	<b>With MUCH Difficulty</b>	<b>UNABLE To Do</b>
<b><u>DRESSING &amp; GROOMING</u></b>				
<b>Are you able to:</b>				
- Dress yourself, including tying Shoelaces and doing buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>ARISING</u></b>				
<b>Are you able to:</b>				
- Stand-up from a straight chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Get in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>EATING</u></b>				
<b>Are you able to:</b>				
- Cut your meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Lift a full cup or glass to your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Open a new milk carton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b><u>COMMENTS</u></b>
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<b><i>I confirm that the information on this module is accurate</i></b>	<b>Patient's Initials:</b>	<b>Date</b>
<b>Investigator's Name:</b>	<b>Staff's Initials:</b>	<b>Date</b>



<b>HEALTH ASSESSMENT QUESTIONNAIRE</b>				
<b>Please tick the response which <u>best describes your usual abilities</u> DURING THE PAST WEEK</b>				
	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do
<b><u>WALKING</u></b> Are you able to:				
- Walk outdoors on level ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Climb up five steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Please tick any AIDS or DEVICES that you usually use for any of the following activities (dressing and grooming, arising, eating, walking):</b>				
<input type="checkbox"/> Cane; <input type="checkbox"/> Crutches; <input type="checkbox"/> Built-up or special utensils; <input type="checkbox"/> Walker;				
<input type="checkbox"/> Wheelchair; <input type="checkbox"/> Special or built-up chair; <input type="checkbox"/> Devices used for dressing:				
<input type="checkbox"/> Other ( <i>specify</i> ): ..... ..... .....				
<b>Please tick any categories for which you usually need HELP FROM ANOTHER PERSON:</b>				
<input type="checkbox"/> Dressing & Grooming; <input type="checkbox"/> Arising; <input type="checkbox"/> Eating; <input type="checkbox"/> Walking;				

<b><i>I confirm that the information on this module is accurate</i></b>	<b>Patient's Initials:</b>	<b>Date</b>
<b>Investigator's Name:</b>	<b>Staff's Initials:</b>	<b>Date</b>





<b>HEALTH ASSESSMENT QUESTIONNAIRE</b>				
<b>Please tick the response which <u>best describes your usual abilities</u> DURING THE PAST WEEK</b>				
	<b>Without ANY Difficulty</b>	<b>With SOME Difficulty</b>	<b>With MUCH Difficulty</b>	<b>UNABLE To Do</b>
<b><u>HYGIENE</u></b>				
<b>Are you able to:</b>				
- Wash and dry your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Take a tub bath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Get on and off the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>REACH</u></b>				
<b>Are you able to:</b>				
- Reach and set down a 2,25 kg object (such as a packet of sugar), from just above your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Bend-down to pick-up clothing from the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>GRIP</u></b>				
<b>Are you able to:</b>				
- Open car doors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Open a jar, previously opened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Turn a tap on and off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b><i>I confirm that the information on this module is accurate</i></b>	<b>Patient's Initials:</b>	<b>Date</b>
<b>Investigator's Name:</b>	<b>Staff's Initials:</b>	<b>Date</b>

<b>HEALTH ASSESSMENT QUESTIONNAIRE</b>				
<b>Please tick the response which <u>best describes your usual abilities</u> DURING THE PAST WEEK</b>				
	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do
<b><u>ACTIVITIES</u></b> Are you able to:				
- Run errands and shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Get in and out of a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Do chores such as vacuuming or gardening?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Please tick any AIDS or DEVICES that you usually use for any of the following activities (hygiene, reach, gripping and opening objects, errands and chores):</b>				
<input type="checkbox"/> Raised toilet seat; <input type="checkbox"/> Bathtub bar; <input type="checkbox"/> Bathtub seat; <input type="checkbox"/> Long-handled appliances for reach; <input type="checkbox"/> Long-handled appliances in bathroom <input type="checkbox"/> Jar opener (for jar previously opened); <input type="checkbox"/> Other (specify): ..... ..... .....				
<b>Please tick any categories for which you usually need HELP FROM ANOTHER PERSON:</b>				
<input type="checkbox"/> Hygiene; <input type="checkbox"/> Reach; <input type="checkbox"/> Gripping and opening objects; <input type="checkbox"/> Errands and chores;				

<b><i>I confirm that the information on this module is accurate</i></b>	<b>Patient's Initials:</b>	<b>Date</b>
<b>Investigator's Name:</b>	<b>Staff's Initials:</b>	<b>Date</b>

# POMS

## APPENDIX E

Name: ..... Date: .....

Below is a list of ratings describing the attitude of other patients. Please read carefully and mark with an X which best describes how you feel.

Key for ratings: 0 = not at all; 1 = a little; 2 = moderate; 3 = very; 4 = extremely

	Not at all A little Moderately Very Extremely		Not at all A little Moderately Very Extremely		Not at all A little Moderately Very Extremely
Friendly	0 1 2 3 4	Unworthy	0 1 2 3 4	Desperate	0 1 2 3 4
Tense	0 1 2 3 4	Spiteful	0 1 2 3 4	Sluggish	0 1 2 3 4
Angry	0 1 2 3 4	Sympathetic	0 1 2 3 4	Rebellious	0 1 2 3 4
Worn-out	0 1 2 3 4	Uneasy	0 1 2 3 4	Helpless	0 1 2 3 4
Unhappy	0 1 2 3 4	Restless	0 1 2 3 4	Weary	0 1 2 3 4
Clear-headed	0 1 2 3 4	Unable to concentrate	0 1 2 3 4	Bewildered	0 1 2 3 4
Lively	0 1 2 3 4	Fatigued	0 1 2 3 4	Alert	0 1 2 3 4
Confused	0 1 2 3 4	Helpful	0 1 2 3 4	Deceived	0 1 2 3 4
Sorry for things done	0 1 2 3 4	Annoyed	0 1 2 3 4	Furious	0 1 2 3 4
Shaky	0 1 2 3 4	Discongraged	0 1 2 3 4	Efficient	0 1 2 3 4
Listless	0 1 2 3 4	Resentful	0 1 2 3 4	Trusting	0 1 2 3 4
Peeved	0 1 2 3 4	Nervous	0 1 2 3 4	Full of Pep	0 1 2 3 4
Considerate	0 1 2 3 4	Lonely	0 1 2 3 4	Bad-tempered	0 1 2 3 4
Sad	0 1 2 3 4	Miserable	0 1 2 3 4	Worthless	0 1 2 3 4
Active	0 1 2 3 4	Muddled	0 1 2 3 4	Forgetful	0 1 2 3 4
On Edge	0 1 2 3 4	Cheerful	0 1 2 3 4	Carefree	0 1 2 3 4
Grouchy	0 1 2 3 4	Bitter	0 1 2 3 4	Terrified	0 1 2 3 4
Blue	0 1 2 3 4	Exhausted	0 1 2 3 4	Guilty	0 1 2 3 4
Energetic	0 1 2 3 4	Anxious	0 1 2 3 4	Vigorous	0 1 2 3 4
Panicky	0 1 2 3 4	Ready to fight	0 1 2 3 4	Uncertain about things	0 1 2 3 4
Hopeless	0 1 2 3 4	Good-natured	0 1 2 3 4	Tired	0 1 2 3 4
Relaxed	0 1 2 3 4	Gloomy	0 1 2 3 4		

(Educational &amp; Industrial Testing Service, 1971)



**APPENDIX F**

**EVALUATION FORMS**

**NAME:** .....

**AGE:** ..... **DR.:** .....

**DISEASE DURATION:** .....

**MEDICATION:** .....

**JOINTS AFFECTED:** .....

**OTHER:** .....

**ASSESSMENT**

	1	2	3
<b>DATE OF ASSESSMENT:</b>	.....	.....	.....
<b><u>PATIENT</u></b>			
1. HAQ	.....	.....	.....
2. POMS	.....	.....	.....
<b><u>CLINICAL</u></b>			
3. Steinbrocker	.....	.....	.....
4. ACR20:	.....	.....	.....
<b><u>LABORATORY</u></b>			
5. ESR	.....	.....	.....
6. Heamoglobin	.....	.....	.....
<b><u>Functional</u></b>			
7. Height	.....	.....	.....
8. Body Mass	.....	.....	.....
9. Blood pressure	.....	.....	.....
10. 15,24m walk	.....	.....	.....



<b>11. Grip strength</b>	R .....	L .....	R .....	L .....	R .....	L .....
<b>12. VO<sup>2</sup> Max</b>						
<b>Relative</b>	.....	.....	.....	.....	.....	.....
<b>Absolute</b>	.....	.....	.....	.....	.....	.....
<b>13. Cybex</b>						
<b>Ham [r]</b>	R .....	L .....	R .....	L .....	R .....	L .....
<b>Ham [a]</b>	R .....	L .....	R .....	L .....	R .....	L .....
<b>Quads [r]</b>	R .....	L .....	R .....	L .....	R .....	L .....
<b>Quads [1]</b>	R .....	L .....	R .....	L .....	R .....	L .....
<b>Ratio</b>	R .....	L .....	R .....	L .....	R .....	L .....
<b>14. Range of Motion</b>						
<b>Wrist [e]</b>	R .....	L .....	R .....	L .....	R .....	L .....
<b>Wrist [d]</b>	R .....	L .....	R .....	L .....	R .....	L .....
<b>Knee [e]</b>	R .....	L .....	R .....	L .....	R .....	L .....
<b>Knee [f]</b>	R .....	L .....	R .....	L .....	R .....	L .....