First Name _____ **Last Name** _____

Date _____

We would like to know how confident you are in doing certain activities. For each of the following questions, please choose the number that corresponds to your confidence that you can do the tasks regularly at the present time.

1. **How confident are you that you can keep the fatigue caused by your disease from interfering with the things you want to do?**

Not At All Confident *Totally Confident*

1 2 3 4 5 6 7 8 9 10

2. **How confident are you that you can keep the physical discomfort or pain of your disease from interfering with the things you want to do?**

Not At All Confident *Totally Confident*

1 2 3 4 5 6 7 8 9 10

3. **How confident are you that you can keep the emotional distress caused by your disease from interfering with the things you want to do?**

Not At All Confident *Totally Confident*

1 2 3 4 5 6 7 8 9 10

4. **How confident are you that you can keep any other symptoms or health problems you have from interfering with the things you want to do?**

Not At All Confident *Totally Confident*

1 2 3 4 5 6 7 8 9 10

5. **How confident are you that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?**

Not At All Confident *Totally Confident*

1 2 3 4 5 6 7 8 9 10

6. **How confident are you that you can do things other than just taking medication to reduce how much your illness affects your everyday life?**

Not At All Confident *Totally Confident*

1 2 3 4 5 6 7 8 9 10