TLS-QoL$_{10}$

1- Does your state of health affect your autonomy ?	❑ Not at all	❑ Moderately	❑ A lot	❑ Extremely
2- Does your state of health affect your usual physical activities ?	❑ Not at all	❑ Moderately	❑ A lot	❑ Extremely
3- Does your condition get in the way of your daily life ?	❑ Not at all	❑ Moderately	❑ A lot	❑ Extremely
4- Do you feel any physical pain ?	❑ Never	❑ Sometimes	❑ Often	❑ Very often
5- Do you feel vulnerable ?	❑ Never	❑ Sometimes	❑ Often	❑ Very often
6- Do you feel isolated ?	❑ Never	❑ Sometimes	❑ Often	❑ Very often
7- Do you fear your condition will worsen ?	❑ Never	❑ Sometimes	❑ Often	❑ Very often
8- Do you feel discouraged ?	❑ Not at all	❑ Moderately	❑ A lot	❑ Extremely
9- Do you feel tired ?	❑ Never	❑ Sometimes	❑ Often	❑ Very often
10-Do you have trouble sleeping ?	❑ Never	❑ Sometimes	❑ Often	❑ Very often

DC-10

1-Do you have feelings of guilt ?	❑ Never	❑ Sometimes	❑ Often	❑ Very often
2- I tend to stay in bed.	❑ Never	❑ Sometimes	❑ Often	❑ Very often
3- Do you feel frustrated about your condition ?	❑ Never	❑ Sometimes	❑ Often	❑ Very often
4- I feel sorry for myself .	❑ Never	❑ Sometimes	❑ Often	❑ Very often
5- Do you allow yourself time for sport or physical exercise ?	❑ Not at all	❑ Moderately	❑ A lot	❑ Extremely
6- Do you feel you can combat your condition ?	❑ Never	❑ Sometimes	❑ Often	❑ Very often
7- I give myself treats whenever I can.	❑ Never	❑ Sometimes	❑ Often	❑ Very often
8- Do you have personal plans ?	❑ Never	❑ Sometimes	❑ Often	❑ Very often
9- Can being better organised improve my health ?	❑ Not at all	❑ Moderately	❑ A lot	❑ Extremely
10- I ask advice from someone I trust .	❑ Never	❑ Sometimes	❑ Often	❑ Very often

Thanks for filling out this questionnaire