**Supplemental Table S1.** Preliminary feline owner-reported orofacial cancer pain quality of life questionnaire (preFORQ/CLIENT)

|  |  |  |  |
| --- | --- | --- | --- |
| During the past 7 days, my cat: | No | If YES,***how often*** did your cat have it? | If YES, ***how severe*** was it usually? |
| Rarely | Sometimes | Usually | Always | Mild | Moderate | Severe | Very severe  |
| **Behavior** |  |  |  |  |  |  |  |  |  |
| 1. Had low energy?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Was reluctant to wake up?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Had altered mood?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Had trouble getting comfortable?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Growled or groaned when resting?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Could not maintain hygiene (i.e., grooming)?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Had decreased appetite?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Drank less water than usual?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Had trouble positioning to defecate/urinate?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| **Activity** |  |  |  |  |  |  |  |  |  |
| 1. Had trouble with mobility?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Fell or lost balance?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Did not do what he/she likes (e.g. chasing, playing, etc.)?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Did not act like his/her normal self?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Had decreased enjoyment of life?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Did not sleep well?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| **Interaction** |  |  |  |  |  |  |  |  |  |
| 1. Was unwilling to be near me?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Showed a decreased amount of affection?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Did not like to be pet or touched?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| **Oral/facial discomfort** |  |  |  |  |  |  |  |  |  |
| 1. Had excessive drooling?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Had difficulty eating his/her normal food?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Was offered and had trouble eating soft food?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Had trouble lying down his/her head?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Felt discomfort or pain near the mouth?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |
| 1. Was defensive when their head was touched?
 | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |

For this final question, please mark an ***X*** along the line to show your cat’s overall ***current*** quality of life

|-----------------------------------------------------------------------------------|

Worst Imaginable Quality of Life Perfect Quality of Life