

FOR ADMINISTRATIVE USE ONLY. TO BE COMPLETED BY STUDY COORDINATOR.

Date of Visit: / / Study ID:

Patient ID: Provider ID:

Thank you for agreeing to participate in our study. The following survey should take about 40 minutes to complete. Please answer all of the questions to the best of your ability. If you have any questions, please ask the study coordinator who gave you this survey. When finished, return the survey to the study coordinator.

1. What is the name of your primary care provider in this clinic?

PRE-EXISTING CONDITIONS

2. Has your doctor ever told you that you have any of the following?

YES NO

- | | | |
|---|---|---|
| a. Hypertension or high blood pressure | 0 | 0 |
| b. Benign prostatic hypertrophy (enlarged prostate) | 0 | 0 |
| c. Chronic low back pain | 0 | 0 |
| d. Congestive heart failure, also called weak heart or fluid on the lungs | 0 | 0 |
| e. Stroke | 0 | 0 |
| f. Arthritis | 0 | 0 |
| g. Angina or coronary heart disease | 0 | 0 |
| h. Heart attack or myocardial infarction | 0 | 0 |
| i. Chronic lung disease (emphysema, asthma, chronic bronchitis or chronic obstructive lung disease) | 0 | 0 |
| j. Cancer (do not include skin cancer, except if it was Melanoma) | 0 | 0 |
| k. Depression | 0 | 0 |
| l. Post-traumatic stress disorder | 0 | 0 |
| m. Schizophrenia | 0 | 0 |
| n. Spinal cord injury with quadriplegia or paraplegia | 0 | 0 |
| o. Diabetes or high blood sugar | 0 | 0 |
| p. Kidney failure (or bad kidneys) | 0 | 0 |
| q. Hepatitis or liver disease | 0 | 0 |
| r. Pancreatitis | 0 | 0 |
| s. High cholesterol (or hyperlipidemia) | 0 | 0 |



HEALTH HABITS

3. How much do you weigh? (in pounds) (Fill in one circle)

- | | | | | |
|---------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--|
| <input type="radio"/> 90 lbs. or less | <input type="radio"/> 131 - 140 lbs. | <input type="radio"/> 181 - 190 lbs. | <input type="radio"/> 231 - 240 lbs. | <input type="radio"/> 281 - 290 lbs. |
| <input type="radio"/> 91 - 100 lbs. | <input type="radio"/> 141 - 150 lbs. | <input type="radio"/> 191 - 200 lbs. | <input type="radio"/> 241 - 250 lbs. | <input type="radio"/> 291 - 300 lbs. |
| <input type="radio"/> 101 - 110 lbs. | <input type="radio"/> 151 - 160 lbs. | <input type="radio"/> 201 - 210 lbs. | <input type="radio"/> 251 - 260 lbs. | <input type="radio"/> 301 - 310 lbs. |
| <input type="radio"/> 111 - 120 lbs. | <input type="radio"/> 161 - 170 lbs. | <input type="radio"/> 211 - 220 lbs. | <input type="radio"/> 261 - 270 lbs. | <input type="radio"/> 311 - 320 lbs. |
| <input type="radio"/> 121 - 130 lbs. | <input type="radio"/> 171 - 180 lbs. | <input type="radio"/> 221 - 230 lbs. | <input type="radio"/> 271 - 280 lbs. | <input type="radio"/> 321 lbs. or more |

4. How tall are you without shoes on? (fill in feet (ft.) and inches (in.)) (If 1/2" please round up)

- | | | | |
|--|----------------------------------|----------------------------------|--|
| <input type="radio"/> 5 ft 00 in or less | <input type="radio"/> 5 ft 04 in | <input type="radio"/> 5 ft 08 in | <input type="radio"/> 6 ft 00 in |
| <input type="radio"/> 5 ft 01 in | <input type="radio"/> 5 ft 05 in | <input type="radio"/> 5 ft 09 in | <input type="radio"/> 6 ft 01 in |
| <input type="radio"/> 5 ft 02 in | <input type="radio"/> 5 ft 06 in | <input type="radio"/> 5 ft 10 in | <input type="radio"/> 6 ft 02 in |
| <input type="radio"/> 5 ft 03 in | <input type="radio"/> 5 ft 07 in | <input type="radio"/> 5 ft 11 in | <input type="radio"/> 6 ft 03 in or more |

5. How often do you engage in regular activities (e.g. brisk walking, jogging, bicycling, etc.) long enough to work up a sweat?

- None
- Less than once a week
- 1 - 2 times per week
- 3 - 4 times per week
- 5 or more times a week

6. Have you used any of the following therapies in the past year?

- | | | | |
|----------------------------|--|--|--|
| a. Acupuncture/Acupressure | <input type="radio"/> Yes <input type="radio"/> No | g. Meditation/Prayer/Spiritual Healing | <input type="radio"/> Yes <input type="radio"/> No |
| b. Chiropractic | <input type="radio"/> Yes <input type="radio"/> No | h. Relaxation/Breathing Exercises | <input type="radio"/> Yes <input type="radio"/> No |
| c. Herbs/Herbal Medicine | <input type="radio"/> Yes <input type="radio"/> No | i. Self-help/Support Groups | <input type="radio"/> Yes <input type="radio"/> No |
| d. Homeopathy | <input type="radio"/> Yes <input type="radio"/> No | j. Special Diet | <input type="radio"/> Yes <input type="radio"/> No |
| e. Imagery | <input type="radio"/> Yes <input type="radio"/> No | k. St John's Wort | <input type="radio"/> Yes <input type="radio"/> No |
| f. Massage | <input type="radio"/> Yes <input type="radio"/> No | l. Vitamins/Minerals | <input type="radio"/> Yes <input type="radio"/> No |

m. Other

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

7. In the past 30 days have you been concerned about having enough food for you or your family?

- YES
- NO

8. In the past 4 weeks, have you been without a permanent address that you call home?

YES

NO

9. Have you ever been without a permanent address that you call home?

YES

NO

10. In the past 4 weeks, have you stayed one or more nights in a shelter, on the street, in a park, or an abandoned building?

YES

NO

11. Have you ever stayed one or more nights in a shelter, on the street, in a park or an abandoned building?

YES

NO

12. Do you now smoke cigars or pipes?

YES

NO

13. Do you now smoke cigarettes (i.e. within the last week)?

YES

NO

14. Have you ever smoked cigarettes for as long as a year?

YES (if yes answer 14 a, b, & c)

NO

a. How many years have you smoked/did you smoke cigarettes? years

b. How many cigarettes do/did you smoke a day? cigarettes

c. If you no longer smoke cigarettes, when did you quit?

LESS THAN 4 WEEKS AGO

MORE THAN 4 WEEKS AGO

15. Do you think HIV causes AIDS?

NO HIV DOES NOT CAUSE AIDS

UNSURE

I AM SURE HIV DOES CAUSE AIDS

16. How often do you have a drink containing alcohol?

- NEVER
- MONTHLY OR LESS
- 2 TO 4 TIMES A MONTH
- 2 TO 3 TIMES A WEEK
- 4 OR MORE TIMES A WEEK

17. How many drinks containing alcohol do you have on a typical day when you are drinking?

- 1 OR 2
- 3 OR 4
- 5 OR 6
- 7 TO 9
- 10 OR MORE

18. How often do you have 6 or more drinks on one occasion?

- NEVER
- LESS THAN MONTHLY
- MONTHLY
- WEEKLY
- DAILY OR ALMOST DAILY

19. How often during the last year have you found that you were not able to stop drinking once you had started?

- NEVER
- LESS THAN MONTHLY
- MONTHLY
- WEEKLY
- DAILY OR ALMOST DAILY

20. How often during the last year have you failed to do what was normally expected from you because of drinking?

- NEVER
- LESS THAN MONTHLY
- MONTHLY
- WEEKLY
- DAILY OR ALMOST DAILY

21. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
- NEVER
 - LESS THAN MONTHLY
 - MONTHLY
 - WEEKLY
 - DAILY OR ALMOST DAILY
22. How often during the last year have you had a feeling of guilt or remorse after drinking?
- NEVER
 - LESS THAN MONTHLY
 - MONTHLY
 - WEEKLY
 - DAILY OR ALMOST DAILY
23. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
- NEVER
 - LESS THAN MONTHLY
 - MONTHLY
 - WEEKLY
 - DAILY OR ALMOST DAILY
24. Have you or someone else been injured as a result of your drinking?
- NO
 - YES, BUT NOT IN THE LAST YEAR
 - YES, DURING THE LAST YEAR
25. Has a relative or friend or doctor or other health care worker been concerned about your drinking or suggested you cut down?
- NO
 - YES, BUT NOT IN THE LAST YEAR
 - YES, DURING THE LAST YEAR
26. Have you cut down or increased drinking since you found out that you were HIV positive, or do you drink the same amount?
- CUT DOWN
 - INCREASED
 - SAME AMOUNT
 - STARTED DRINKING

The following questions concern information about your possible involvement with drugs not including alcohol beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then fill in the circle to the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various class of drugs may include: cannabis (marijuana, hashish), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD), or narcotics (e.g. heroin). Remember that the questions do not include alcohol beverages.

These questions refer to the last 12 months.

	YES	NO
27. Have you used drugs other than those required for medical reasons?	0	0
28. Do you abuse more than one drug at a time?	0	0
29. Are you always able to stop using drugs when you want to?	0	0
30. Have you had "blackout" or "flashbacks" as a result of drug use?	0	0
31. Do you ever feel bad or guilty about your drug use?	0	0
32. Does your spouse (or parents) ever complain about your involvement with drugs?	0	0
33. Have you neglected your family because of your use of drugs?	0	0
34. Have you engaged in illegal activities in order to obtain drugs?	0	0
35. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	0
36. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	0	0

37. When did you get your first HIV test that was positive?

 /

MONTH / YEAR

NEVER HAD A POSITIVE TEST

38. After you got your first positive HIV test result, how many months was it until you got medical care for HIV? Meaning more testing or an examination?

Months

BEHAVIOR

39. In order to compare our study with the results of other studies, we'd like to know if you have ever done any of the following things.

Have you:	<u>YES</u>	<u>NO</u>	<u>DON'T KNOW</u>
a. Had sex with a man?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Had sex with a woman?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Injected drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Had sex with someone you know or believe to have been an IV or injected drug user?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Had sex with someone you know or believe to have been bisexual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Received clotting factor for hemophilia or there blood clotting disorder?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Received transfusion of blood components other than clotting factor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The next questions are about your sexual behavior. By sex we mean oral, vaginal, or anal sex, but NOT masturbation. When we talk about condoms, we mean both male as well as female condoms.

40. During the past 12 months, have you had sex?

YES

NO [SKIP to NO 45 on Next Page]

41. During the past 12 months, with how many people have you had sex? people

42. During the past 12 months, have you had sex with only males, only females, or with both males and females?

ONLY MALES

ONLY FEMALES

BOTH MALES AND FEMALES

43. Thinking back about the last time you had sex, did you or your partner use a condom?

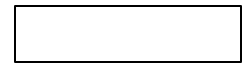
YES

NO

44. Thinking back about the last time you had sex, were you under the influence of alcohol or drugs?

YES

NO



45. Have you ever, even once, used a needle to inject any drug?

DO NOT include anything you took under a doctor's orders.

YES

NO [SKIP to NO 54]

46. In the past 12 months, have you ever used a needle to inject any drug?

YES

NO [SKIP to NO 54]

47. The last time that you used a needle to inject a drug, what drug did you inject?

HEROIN

POWDER COCAINE

CRACK COCAINE

METHAMPHETAMINE

OTHER, specify

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

48. The last time you used a needle to inject a drug, was it a new sterile needle?

By sterile, we mean that it had never been used before, not even by you?

YES

NO

DON'T KNOW

49. The last time you used a needle to inject a drug, did you use cottons, a cooker, or rinse water that you knew or suspected someone else had used before?

YES

NO

DON'T KNOW

50. The last time you used a needle to inject a drug, did someone else use the needle after you?

YES

NO

DON'T KNOW

51. The last time you used a needle to inject a drug, did someone else use the cottons, cooker, or rinse water after you?

YES

NO

DON'T KNOW

52. The last time you used a needle to inject a drug, did someone use their syringe to squirt the drug into your syringe? This is sometimes called "backloading", "frontloading", or "splitting".

YES

NO

DON'T KNOW

53. The last time you used a needle to inject a drug, did you use your syringe to squirt the drug into the syringe of someone else? This is sometimes called "frontloading", "backloading", or "splitting".

YES

NO

DON'T KNOW

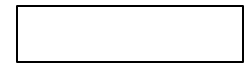
SOCIAL ASPECTS OF HEALTH

54. For each of the following statements, fill in the circle if you strongly agree, agree, disagree, or strongly disagree.

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
a. I want to take an active role in the medical management of my disease and its complications	0	0	0	0
b. It is better to trust a doctor or nurse in charge of a medical procedure than to question what they are doing	0	0	0	0
c. I want to know as much as I can about the medical aspects of my disease and treatment	0	0	0	0
d. I'd rather have doctors and nurses make decisions about what's best rather than for them to give me a lot of choices	0	0	0	0

55. How often do you see or hear from relatives or close friends? Would you say less than once a month, about once a month, a few times a month, a few times a week, every day?

	LESS THAN ONCE A MONTH	MONTHLY	A FEW TIMES A MONTH	A FEW TIMES A WEEK	DAILY
a. Relatives?	0	0	0	0	0
b. Close friends?	0	0	0	0	0



56. How many close friends or family do you have with whom you feel at ease, can talk about private matters, or can call on for help?

- NONE
- ONE
- TWO
- THREE OR FOUR
- FIVE OR EIGHT
- NINE OR MORE

57. In response to having a medical illness, how often during the past four weeks have you done each of the following? Would you say all of the time, most of the time, a good bit of the time, some of the time, a little of the time, or none of the time?

	ALL OF THE TIME	MOST OF THE TIME	A GOOD BIT OF THE TIME	SOME OF THE TIME	LITTLE OF THE TIME	NONE OF THE TIME
--	--------------------	---------------------	------------------------------	---------------------	--------------------------	---------------------

a. Used my situation to change or grow as a person?

b. Avoided being with people in general?

c. Kept yourself from thinking too much about it?

d. Asked other people for advice and information?

e. Criticized or lectured yourself?

f. Tried to keep yourself from worrying about it?

g. Talked to someone about how you were feeling about having it?

h. Tried to keep it from bothering you?

i. Involved yourself in volunteer work or a community organization?

58. Are you an official member of a church or other place of worship?

- YES
- NO

59. How religious do you consider yourself?

- NOT AT ALL RELIGIOUS
- NOT VERY RELIGIOUS
- SOMEWHAT RELIGIOUS
- RELIGIOUS
- VERY RELIGIOUS

60. During the past year, how often did you attend religious services?

- NEVER
- LESS THAN TWICE A YEAR
- SEVERAL TIMES A YEAR
- ABOUT ONCE A MONTH
- TWO TO THREE TIMES A MONTH
- EVERY WEEK
- SEVERAL TIMES A WEEK
- EVERYDAY

61. How frequently do you pray?

- NEVER
- LESS THAN TWICE A YEAR
- SEVERAL TIMES A YEAR
- ABOUT ONCE A MONTH
- TWO TO THREE TIMES A MONTH
- EVERY WEEK
- SEVERAL TIMES A WEEK
- EVERY DAY



62. How important is religion to you?

- VERY IMPORTANT
- IMPORTANT
- SOMEWHAT IMPORTANT
- NOT VERY IMPORTANT
- NOT AT ALL IMPORTANT

63. When you have problems or difficulties in your life, how often do you seek spiritual comfort and support?

- ALMOST ALWAYS
- OFTEN
- SOMETIMES
- RARELY
- NEVER

64. If you compare your life now to before HIV, would you say your life is:

- BETTER NOW
- WORSE NOW
- ABOUT THE SAME AS BEFORE I KNEW I WAS HIV POSITIVE
- DON'T KNOW

HEALTH CARE UTILIZATION

65. How many times have you used VA health care in the last 4 months?

a. For overnight stays in a hospital or nursing home

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

b. For outpatient care

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

66. How many times have you used health care outside the VA in the last 4 months?

a. For overnight stays in a hospital or nursing home

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

b. For outpatient care

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

67. Within the past 4 months, how many visits have you had with a **mental health professional** within the VA?

- 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

68. Within the past 4 months, how many visits have you had with a **mental health professional** outside the VA?

- 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

The following questions ask for your views about your regular doctor. This information will help us to improve the quality of your care. Your doctor will not be able to link your name to your responses.

69. Do you have one person you think of as your regular doctor?

- YES, VA
- YES, NON-VA
- NO

70. How many minutes does it usually take you to get to your regular doctor's office?

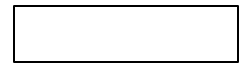
- 15 OR LESS
- 16 - 30
- 31 - 60
- 60 OR MORE

71. How would you rate the convenience of your regular doctor's office location?

- VERY POOR
- POOR
- FAIR
- GOOD
- VERY GOOD
- EXCELLENT

72. Thinking about talking with your regular doctor, how would you rate the following?

	<u>VERY POOR</u>	<u>POOR</u>	<u>FAIR</u>	<u>GOOD</u>	<u>VERY GOOD</u>	<u>EXCELLENT</u>
a. Thoroughness of your doctor's questions about your symptoms and how you are feeling	0	0	0	0	0	0
b. Attention your doctor gives to what you have to say	0	0	0	0	0	0
c. Doctor's explanation of your problems or treatment that you need	0	0	0	0	0	0



73. Thinking about how well your regular doctor knows you, how would you rate your doctor's knowledge of what worries you most about your health?

- VERY POOR
- POOR
- FAIR
- GOOD
- VERY GOOD
- EXCELLENT

74. All things considered, how much do you trust your regular doctor?

Completely 1 2 3 4 5 6 7 8 9 10 Not at All

75. Did you know who to ask when you had questions about your care?

- YES, ALWAYS
- YES, SOMETIMES I DID
- NO
- DIDN'T HAVE ANY QUESTIONS

76. Did you know what the next step in your care would be?

- YES, ALWAYS
- YES, SOMETIMES
- NO

77. Have any of the following been a problem for you in arranging for your medical care in the last 12 months?

	<u>YES, A BIG PROBLEM</u>	<u>YES, A SMALL PROBLEM</u>	<u>NO, NOT A PROBLEM</u>
a. Difficulty receiving care you and your doctor believed necessary	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Not being able to get a referral to a specialist that you wanted to see	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

78. Overall, how would you rate the quality of care you received the past two months?

- VERY POOR
- POOR
- FAIR
- GOOD
- VERY GOOD
- EXCELLENT

MEDICATIONS: Most people with HIV have many pills to take at different times during the day, and find it hard to always remember their pills. Please tell us what you are doing. Don't worry about telling us that you don't take all your doses. We need to know what is really happening, not what you think we "want to hear." Please fill in the circle of the one response that best describes how you take your medications.

79. Do you take any medicine to treat your HIV infection? YES NO
80. During the past 4 days, on how many days have you missed taking any of your doses?
- NONE
 - ONE DAY
 - TWO DAYS
 - THREE DAYS
 - FOUR DAYS
81. Most anti-HIV medications need to be taken on a schedule, such as "2 times a day," or "3 times a day," or "every 8 hours." How closely did you follow your specific schedule over the last four days?
- NEVER
 - SOME OF THE TIME
 - ABOUT HALF OF THE TIME
 - MOST OF THE TIME
 - ALL OF THE TIME
82. Did you miss any of your anti-HIV medication last weekend--last Saturday or Sunday?
- YES NO
83. When was the last time you missed any of your HIV medications?
- WITHIN THE PAST WEEK
 - 1 - 2 WEEKS AGO
 - 2 - 4 WEEKS AGO
 - 1 - 3 MONTHS AGO
 - OVER 3 MONTHS AGO
 - NEVER SKIPPED
84. Do you take any prescription medicine to treat other medical problems you may have?
- YES NO
85. Over the past 4 days, on how many days did you miss taking any of your doses?
- NONE
 - ONE DAY
 - TWO DAYS
 - THREE DAYS
 - FOUR DAYS

SYMPTOMS

86. The following questions ask about symptoms you might have had during the past four weeks. Please fill in the circle of the one response that best describes how much you have been bothered by this symptom.

	I HAVE THIS SYMPTOM AND...				
	I DO NOT HAVE THIS SYMPTOM	IT DOESN'T BOTHER ME	IT BOTHERS ME A LITTLE	IT BOTHERS ME	IT BOTHERS ME A LOT
a. Fatigue or loss of energy?	0	0	0	0	0
b. Fevers, chills, or sweats?	0	0	0	0	0
c. Feeling dizzy or light headed?	0	0	0	0	0
d. Pain, numbness, or tingling in the hands or feet?	0	0	0	0	0
e. Trouble remembering?	0	0	0	0	0
f. Nausea or vomiting?	0	0	0	0	0
g. Diarrhea or loose bowel movements?	0	0	0	0	0
h. Felt sad, down, or depressed?	0	0	0	0	0
i. Felt nervous or anxious?	0	0	0	0	0
j. Difficulty falling or staying asleep?	0	0	0	0	0
k. Skin problems, such as rash, dryness, or itching?	0	0	0	0	0
l. Cough or trouble catching your breath?	0	0	0	0	0
m. Headache?	0	0	0	0	0
n. Loss of appetite or change in the taste of food?	0	0	0	0	0
o. Bloating, pain, or gas in your stomach?	0	0	0	0	0
p. Muscle aches or joint pain?	0	0	0	0	0
q. Problems with having sex, such as loss of interest or lack of satisfaction?	0	0	0	0	0
r. Changes in the way your body looks, such as fat deposits or weight gain?	0	0	0	0	0
s. Problems with weight loss or wasting?	0	0	0	0	0
t. Hair loss or changes in the way your hair looks?	0	0	0	0	0

87. Do you think your symptoms are caused by the drugs you take to treat your HIV infection?

YES	UNSURE	NO
0	0	0

88. Do you think your symptoms are caused by the drugs you take to treat other medical conditions?

YES	UNSURE	NO
0	0	0

QUALITY OF LIFE

89. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
a. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Trouble falling/staying asleep, sleeping to much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

90. If you checked off any problem listed above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- NOT DIFFICULT AT ALL
- SOMEWHAT DIFFICULT
- VERY DIFFICULT
- EXTREMELY DIFFICULT

**Questions 91a-g are from the Beck Depression Inventory®-II (BDI®-II).
The BDI®-II is protected by federal copyright law.**

92. These questions are about any physical limitations you might have. For these activities, please indicate which response best describes you by darkening the circle under the appropriate response after EACH STATEMENT.

	YES, I CAN DO THIS	YES, BUT ONLY SLOWLY	NO, I CANNOT DO THIS
a. Can you do heavy work at home, like scrubbing floors, lifting or moving heavy furniture?	0	0	0
b. Can you do moderate work at home like moving a chair or table, or pushing a vacuum cleaner?	0	0	0
c. Can you do light work around the house like dusting or washing dishes?	0	0	0
d. If you want to, can you participate in active sports such as swimming, tennis, basketball, volleyball or rowing a boat?	0	0	0
e. If you want to, can you run a short distance?	0	0	0
f. Can you walk uphill or upstairs?	0	0	0
g. Can you walk a block or more?	0	0	0
h. Can you walk around inside the house?	0	0	0
i. Can you walk to a table for meals?	0	0	0
j. Can you dress yourself?	0	0	0
k. Can you eat without help?	0	0	0
l. Can you use the bathroom without help?	0	0	0

These questions ask for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer each question by filling in the circle. If you are unsure about how to answer, please give the best answer you can.

93. In general, would you say your health is:

- EXCELLENT
- VERY GOOD
- GOOD
- FAIR
- POOR



The following items are about activities you might do during a typical day.
Does your health now limit you in these activities? If so, how much?

	YES, LIMITED A LOT	YES, LIMITED A LITTLE	NO, NOT LIMITED AT ALL
94. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	0	0	0
95. Climbing several flights of stairs	0	0	0

During the past 4 weeks, have you had any of the following problems with your work or other daily activities as a result of your physical health?

- 96. **Accomplished less** than you would like
 - YES
 - NO
- 97. Were limited in the **kind** of work or other activities
 - YES
 - NO

During the past 4 weeks, have you had any of the following problems with you work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

- 98. **Accomplished less** than you would like YES NO
- 99. Didn't do work or other activities as **carefully** as usual YES NO

- 100. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
 - NOT AT ALL
 - A LITTLE BIT
 - MODERATELY
 - QUITE A BIT
 - EXTREMELY

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks -

	ALL OF THE TIME	MOST OF THE TIME	A GOOD BIT OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
101. Have you felt calm and peaceful?	0	0	0	0	0	0
102. Did you have a lot of energy?	0	0	0	0	0	0
103. Have you felt downhearted and blue?	0	0	0	0	0	0

104. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- ALL OF THE TIME
- MOST OF THE TIME
- SOME OF THE TIME
- A LITTLE OF THE TIME
- NONE OF THE TIME

DEMOGRAPHICS

105. What is the highest grade or year of school you completed?

- NEVER ATTENDED SCHOOL OR ONLY KINDERGARTEN
- GRADES 1 THROUGH 8 (ELEMENTARY)
- GRADES 9 THROUGH 11 (SOME HIGH SCHOOL)
- HIGH SCHOOL GRADUATE
- GED
- COLLEGE 1 YEAR TO 3 YEARS (SOME COLLEGE OR TECHNICAL SCHOOL)
- COLLEGE GRADUATE
- GRADUATE SCHOOL

106. What is your race/ethnicity? (mark all that apply)

- AMERICAN INDIAN OR ALASKAN NATIVE
- ASIAN
- BLACK OR AFRICAN AMERICAN
- SPANISH, HISPANIC, OR LATINO
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- WHITE

107. What is your current marital status?

- MARRIED
- DIVORCED
- SEPERATED
- WIDOWED
- NEVER MARRIED
- LIVING WITH PARTNER

108. How many persons live in your household?

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109. Are you currently...(mark all that apply)

- EMPLOYED FOR WAGES
- SELF-EMPLOYED
- LOOKING FOR WORK AND UNEMPLOYED FOR MORE THAN ONE YEAR
- LOOKING FOR WORK AND UNEMPLOYED FOR LESS THAN ONE YEAR
- HOMEMAKER
- STUDENT
- RETIRED
- UNABLE TO WORK

110. What is your annual household income?

- LESS THAN \$6,000
- \$6,000 TO \$11,999
- \$12,000 TO \$24,999
- \$25,000 TO \$49,999
- OVER \$50,000

111. What is your sex?

- MALE
- FEMALE

**Thank you for completing our questionnaire.
Please return this to the Survey Coordinator who gave it to you.**