Marshall University
Robert C. Byrd Center for Rural Health

Questionnaire

For the
Help Yourself
Chronic Disease Self - Management Program

Adapted from:

Stanford Patient Education Research Center
Stanford University School of Medicine
http://patienteducation.stanford.edu/

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Name: _____ Today's date: _____

Address: _____

City, state, zip: _____

Telephone: home (____) _____ - _____ Date of birth: _____

work (____) _____ - _____ Sex: ☐Female ☐ Male

Background

1. Ethnic origin *(check ☐only one)*:

☐ White not Hispanic
☐ Black not Hispanic
☐ Hispanic
☐ Asian or Pacific Islander
☐ Filipino
☐ American Indian/Alaskan Native
☐ Other: _____

2. Please circle the *highest* year of school completed:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 above 22
(primary) *(high school)* *(college)* *(graduate school)*

3. Are you currently *(check ☐only one)*:

☐ married ☐ separated ☐ widowed
☐ single ☐ divorced

4. Please indicate below which chronic condition(s) you have:

☐ Diabetes ☐ Asthma ☐ Emphysema or COPD

☐ Other lung disease *Type of lung disease:* _____

☐ Heart disease *Type of heart disease:* _____

☐ Arthritis or other rheumatic disease *Specify type:* _____

☐ Cancer *Type of cancer:* _____

☐ Other chronic condition *Specify:* _____

General Health

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

(Circle one)

Excellent 1

Very good.....2

Good.....3

Fair 4

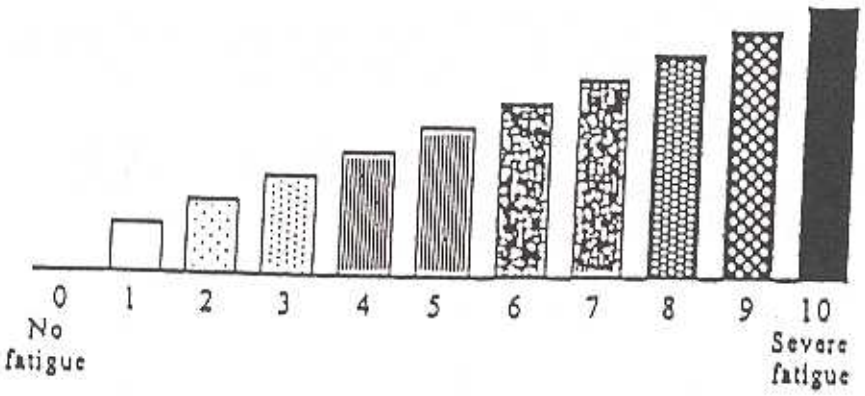
Poor.....5

Symptoms

How much time during the past 2 weeks...

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
1. Did you feel worn out?	0	1	2	3	4	5
2. Were you discouraged by your health problems?	0	1	2	3	4	5
3. Did you have a lot of energy?	0	1	2	3	4	5
4. Were you fearful about your future health?	0	1	2	3	4	5
5. Did you feel tired?	0	1	2	3	4	5
6. Was your health a worry in your life?	0	1	2	3	4	5
7. Did you feel full of pep?	0	1	2	3	4	5
8. Were you frustrated by your health problems?	0	1	2	3	4	5
9. Did you have enough energy to do the things you wanted to do?	0	1	2	3	4	5

1. We are interested in learning whether or not you are affected by fatigue. Please *circle* the *number* below that describes your fatigue in the past 2 weeks:



2. We are interested in knowing if anything you learned in the course has had a lasting effect on your life. (Please circle one)

YES NO

3. If yes, please describe:

Physical Activities

During the past week, even if it was not a typical week, how much total time*(for the entire week)* did you spend on each of the following? *(Please circle one number for each question.)*

	none	less than 30 min/wk	30–60 min/wk	1-3 hrs per week	more than 3 hrs/wk
1. Stretching or strengthening exercises (range of motion, using weights, etc.)	0	1	2	3	4
2. Walk for exercise	0	1	2	3	4
3. Swimming or aquatic exercise	0	1	2	3	4
4. Bicycling (including stationary exercise bikes)	0	1	2	3	4
5. Other aerobic exercise equipment (stairmaster, skiing, healthrider, etc.)	0	1	2	3	4
6. Other aerobic exercise *Specify*_____	0	1	2	3	4

Coping With Symptoms

When you are feeling down in the dumps, feeling pain or having other unpleasant symptoms, how often do you *(Please circle one number for each question):*

	Never	Almost never	Some-times	Fairly often	Very often	Always
1. Try to feel distant from the discomfort and pretend that it is not part of your body	0	1	2	3	4	5
2. Don't think of it as discomfort but as some other sensation, like a warm, numb feeling	0	1	2	3	4	5
3. Play mental games or sing songs to keep your mind off the discomfort	0	1	2	3	4	5
4. Practice progressive muscle relaxation	0	1	2	3	4	5
5. Practice visualization or guided imagery, such as picturing yourself somewhere else	0	1	2	3	4	5
6. Talk to yourself in positive ways	0	1	2	3	4	5

Physical Abilities

Please check (☐) the one best answer for your abilities.

At this moment, are you able to:	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
1. Dress yourself, including tying shoelaces and doing buttons?	☐	☐	☐	☐
2. Get in and out of bed?	☐	☐	☐	☐
3. Lift a full cup or glass to your mouth?	☐	☐	☐	☐
4. Walk outdoors on flat ground?	☐	☐	☐	☐
5. Wash and dry your entire body?	☐	☐	☐	☐
6. Bend down to pick up clothing from the floor?	☐	☐	☐	☐
7. Turn faucets on and off?	☐	☐	☐	☐
8. Get in and out of a car?	☐	☐	☐	☐

How Your Illness Affects Your Life

The following items ask about how much your illness(es) and/or its treatment interfere with your life. *Please circle the one number that best describes your current life situation.* If an item is not applicable, please check (☐) the box to indicate that this aspect of your life is not affected. Please do not leave any item unanswered.

How much does your illness(es) and/or its treatment interfere with:

1. Your feeling of being healthy ☐ Not applicable

   Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

2. The things you eat and drink ☐ Not applicable

   Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

3. Your work, including job, house work, chores, or errands ☐ Not applicable

   Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

How much does your illness(es) and/or its treatment interfere with :

4. Playing sports, gardening, or other physical recreation or hobbies ☐Not applicable

Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

5. Quiet recreation or hobbies, such as reading, TV, music, knitting, etc. ☐Not applicable

Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

6. Your financial situation ☐ Not applicable

Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

7. Your relationship with your spouse or domestic partner ☐ Not applicable

Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

8. Your sex life ☐ Not applicable

Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

9. Your relationship and social activities with your family ☐ Not applicable

Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

10. Social activities with your friends, neighbors, or groups ☐ Not applicable

Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

11. Your religious or spiritual activities ☐ Not applicable

Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

12. Your involvement in community or civic activities ☐ Not applicable

Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

13. Your self-improvement or self-expression activities ☐ Not applicable

Not very much ☐ 1.....2.....3.....4.....5.....6.....7 ☐Very much

Confidence About Doing Things

For each of the following questions, please *circle* the number that corresponds with your confidence that you can do the tasks regularly at the present time.

How confident are you that you can...

1. Keep the fatigue caused by your disease from interfering with the things you want to do?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident
2. Keep the physical discomfort or pain of your disease from interfering with the things you want to do?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident
3. Keep the emotional distress caused by your disease from interfering with the things you want to do?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident
4. Keep any other symptoms or health problems you have from interfering with the things you want to do?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident
5. 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	1	2	3	4	5	6	7	8	9	10 totally confident
6. Do things other than just taking medication to reduce how much your illness affects your everyday life?	not at all confident	1	2	3	4	5	6	7	8	9	10 totally confident

Feelings

Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week: *(circle one number on each line)*

During the past week...	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7days)
1. I was bothered by things that usually don't bother me	0	1	2	3
2. I had trouble keeping my mind on what I was doing	0	1	2	3
3. I felt depressed	0	1	2	3

During the past week...	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7days)
4. I felt that everything I did was an effort	0	1	2	3
5. I felt hopeful about the future	0	1	2	3
6. I felt fearful	0	1	2	3
7. My sleep was restless	0	1	2	3
8. I was happy	0	1	2	3
9. I felt lonely	0	1	2	3
10. I could not "get going"	0	1	2	3

Daily Activities

During the past 4 weeks, how much... *(Circle one)*

	Not at all	Slightly	Moderately	Quite a bit	Almost totally
1. Has your health interfered with your normal social activities with family, friends, neighbors or groups	0	1	2	3	4
2. Has your health interfered with your hobbies or recreational activities	0	1	2	3	4
3. Has your health interfered with your household chores	0	1	2	3	4
4. Has your health interfered with your errands and shopping	0	1	2	3	4

Only one more page to go!

Medical Care

1. When you visit your doctor, how often do you do the following *(please circle one number for each question):*

	Never	Almost never	Some-times	Fairly often	Very often	Always
a. Prepare a list of questions for your doctor	0	1	2	3	4	5
b. Ask questions about the things you want to know and things you don't understand about your treatment	0	1	2	3	4	5
c. Discuss any personal problems that may be related to your illness	0	1	2	3	4	5

2. In the past 6 months, how many times did you visit a physician?
Do NOT include visits while in the hospital. _____ visits

a. Did you go outside *(name of system here)* for any of these visits? ☐ Yes ☐ No

b. Were any of the above visits to a chiropracter, acupuncturist, podiatrist, or other alternative health provider? ☐ Yes ☐ No
If yes, how many visits? _____ visits

c. Were any of the above visits to a psychiatrist, psychologist, family counselor, social worker, or other mental health provider? ☐ Yes ☐ No
If yes, how many visits? _____ visits

d. Were any of the above visits to a hospital emergency room? ☐ Yes ☐ No
If yes, how many visits? _____ visits

4. In the past 6 months, how many TIMES were you hospitalized for one night or longer? _____ times

a. How many total NIGHTS did you spend in the hospital in the past 6 months? _____ nights

b. Were all of these hospitalizations covered by your [redacted] Health Plan? ☐ Yes ☐ No

c. Were any of these hospitalizations at a skilled nursing facility, convalescent hospital, or other minimum care facility? ☐ Yes ☐ No

Thank you for your help!

Current Use of Self-Management

1. I continue to make action plans to help me manage my chronic condition:

(Circle one)

Most of the time 1

Some of the time 2

Little of the time 3

None of the time.....4

2. I continue to use the following information and skills learned in the Help Yourself course:

(Check all that apply)

Healthy Eating (i.e. balancing my plate)..... ☐

Physical Activity (i.e. walking, stretching)..... ☐

Cognitive (Thinking) Activities .....

Breathing techniques ..... ☐

Guided imagery..... ☐

Relaxation..... ☐

Positive Self-Talk..... ☐

Distraction..... ☐