

**FORM E****ACTION study****Baseline interview**

1. Date and type of assessment		
1.01	Interviewer code	_
1.02	Date of assessment (i.e. the date the information was collected)	_ _ _ _ _   20_ _ _ _

2. Demographic information		
2.01	Marital status	<input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
2.02	Are you the household head? If yes, go to Q2.04	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.03	Relationship to household head	<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other, please specify:
2.04	Number of people in the household on a permanent basis?	_ _ _

2.05	Number of people under the age of 18 years in your household	_ _ _
2.06	Number of people over the age of 65 years in your household	_ _ _
2.07	About how many close friends do you have? These are people you feel at ease with, can talk to about private matters, or call on for help.	_ _ _
2.08	Who paid for your treatment ( <i>if appropriate tick more than 1 box</i> )	<input type="checkbox"/> You and your family <input type="checkbox"/> Other relatives <input type="checkbox"/> Friends <input type="checkbox"/> Insurance <input type="checkbox"/> Government <input type="checkbox"/> Community organization, including religious charities <input type="checkbox"/> Other, please specify:
2.09	Do you have any of the following types of health care insurance? <i>Tick all that apply.</i>	<input type="checkbox"/> Government provided insurance <input type="checkbox"/> Employment based insurance <input type="checkbox"/> Private insurance <input type="checkbox"/> Other community insurance
2.10	Highest educational attainment ( <i>please tick only one</i> )	<input type="checkbox"/> No School <input type="checkbox"/> Primary (6 years) <input type="checkbox"/> Secondary/High school (7-12 years) <input type="checkbox"/> Technical/Vocational school <input type="checkbox"/> College/University
2.11	What has been your main occupation to date throughout your life? ( <i>please tick only one</i> )	<input type="checkbox"/> Manager <input type="checkbox"/> Professional <input type="checkbox"/> Technician <input type="checkbox"/> Clerical support worker <input type="checkbox"/> Service and sales worker

		<ul style="list-style-type: none"><li><input type="checkbox"/> Agricultural, forestry and fishery worker</li><li><input type="checkbox"/> Craft and related trades worker</li><li><input type="checkbox"/> Factory labourer</li><li><input type="checkbox"/> In military</li></ul>
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3. Household economic information		
3.01	Do you receive any social welfare payments or pension from the government?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.02	Do you have paid work, either for a wage or self-employed? If no, please proceed to Q3.07	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.03	In the last 12 months, how many months did you spend doing any paid work?	_ _ _
3.04	On average, how many days per week do you usually do paid work?	_ _ _
3.05	On average, how many hours per day do you usually do paid work?	_ _ _
3.06	Please describe your <i>current</i> occupation. ( <i>please tick only one</i> )	<input type="checkbox"/> Manager <input type="checkbox"/> Professional <input type="checkbox"/> Technician <input type="checkbox"/> Clerical support worker <input type="checkbox"/> Service and sales worker <input type="checkbox"/> Agricultural, forestry and fishery worker <input type="checkbox"/> Craft and related trades worker <input type="checkbox"/> Factory labourer <input type="checkbox"/> In military <input type="checkbox"/> Unemployed/not working <input type="checkbox"/> Retired with pension <input type="checkbox"/> Retired without pension
3.07	Do you usually perform house work (e.g. cooking, cleaning, taking care of the children, etc) If no, proceed to Q3.10	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.08	On average, how many days per week do you usually do house work?	_ _ _
3.09	On average, how many hours per day do you usually do	

	house work?	_ _ _
3.10	Over the past 12 months, what is the total income received from all members of your household (your income included)?	Currency:  _ _ _ _  Amount per year:  _ _ _ _ _ _ _ _ _
3.11	Main source of household income: <i>(please tick only one)</i>	<input type="checkbox"/> Crops <input type="checkbox"/> Agricultural sidelines (e.g. Livestock, hunting, domesticating wild animals) <input type="checkbox"/> Family business <input type="checkbox"/> Wages <input type="checkbox"/> Remittances & gifts <input type="checkbox"/> Other income
3.12	Do you/does your household: <i>(tick all that apply)</i>	<input type="checkbox"/> Own land <input type="checkbox"/> Own a car <input type="checkbox"/> Own a motor bike <input type="checkbox"/> Have electricity <input type="checkbox"/> Have running water <input type="checkbox"/> Contain a toilet facility indoors <input type="checkbox"/> Have children of schooling age who are NOT attending school (7-13)

#### 4. Quality of life (EQ 5D)

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

##### **Mobility**

- I have no problems in walking around  PLEASE TICK
- I have some problems in walking around  ONE BOX
- I am confined to bed

##### **Personal Care**

- I have no problems with personal care  PLEASE TICK
- I have some problems washing or dressing myself  ONE BOX
- I am unable to wash or dress myself

##### **Usual Activities** (e.g. work, study, housework, family or leisure activities)

- I have no problems with performing my usual activities  PLEASE TICK
- I have some problems with performing my usual activities  ONE BOX
- I am unable to perform my usual activities

##### **Pain/Discomfort**

- I have no pain or discomfort  PLEASE TICK
- I have moderate pain or discomfort  ONE BOX
- I have extreme pain or discomfort

##### **Anxiety/Depression**

- I am not anxious or depressed  PLEASE TICK
- I am moderately anxious or depressed  ONE BOX
- I am extremely anxious or depressed

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

**Your own  
health state  
today**

Best  
imaginable  
health state

100

90

80

70

60

50

40

30

20

10

0

Worst  
imaginable  
health state

## 5. Quality of Life (EORTC)



### EORTC QLQ-C30 (version 3)

We are interested in some things about you and your health. Please answer all of the questions yourself by circling the number that best applies to you. There are no "right" or "wrong" answers. The information that you provide will remain strictly confidential.

Please fill in your initials:

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Your birthdate (Day, Month, Year):

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

Today's date (Day, Month, Year):

31

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	Not at All	A Little	Quite a Bit	Very Much
1. Do you have any trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase?	1	2	3	4
2. Do you have any trouble taking a <u>long</u> walk?	1	2	3	4
3. Do you have any trouble taking a <u>short</u> walk outside of the house?	1	2	3	4
4. Do you need to stay in bed or a chair during the day?	1	2	3	4
5. Do you need help with eating, dressing, washing yourself or using the toilet?	1	2	3	4

#### During the past week:

	Not at All	A Little	Quite a Bit	Very Much
6. Were you limited in doing either your work or other daily activities?	1	2	3	4
7. Were you limited in pursuing your hobbies or other leisure time activities?	1	2	3	4
8. Were you short of breath?	1	2	3	4
9. Have you had pain?	1	2	3	4
10. Did you need to rest?	1	2	3	4
11. Have you had trouble sleeping?	1	2	3	4
12. Have you felt weak?	1	2	3	4
13. Have you lacked appetite?	1	2	3	4
14. Have you felt nauseated?	1	2	3	4
15. Have you vomited?	1	2	3	4
16. Have you been constipated?	1	2	3	4

Please go on to the next page

**During the past week:**

	Not at All	A Little	Quite a Bit	Very Much
17. Have you had diarrhea?	1	2	3	4
18. Were you tired?	1	2	3	4
19. Did pain interfere with your daily activities?	1	2	3	4
20. Have you had difficulty in concentrating on things, like reading a newspaper or watching television?	1	2	3	4
21. Did you feel tense?	1	2	3	4
22. Did you worry?	1	2	3	4
23. Did you feel irritable?	1	2	3	4
24. Did you feel depressed?	1	2	3	4
25. Have you had difficulty remembering things?	1	2	3	4
26. Has your physical condition or medical treatment interfered with your <u>family</u> life?	1	2	3	4
27. Has your physical condition or medical treatment interfered with your <u>social</u> activities?	1	2	3	4
28. Has your physical condition or medical treatment caused you financial difficulties?	1	2	3	4

**For the following questions please circle the number between 1 and 7 that best applies to you**

29. How would you rate your overall health during the past week?

1      2      3      4      5      6      7

Very poor

Excellent

30. How would you rate your overall quality of life during the past week?

1      2      3      4      5      6      7

Very poor

Excellent

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## 6. Psycho-social (HADS)

### Hospital Anxiety and Depression Scale (HADS)

Please tick or circle the most correct answer. Don't spend too long thinking about each answer. Answer as you are feeling now.

I feel tense or 'wound up':	Most of the time	3	A
	A lot of the time	2	
	From time to time, occasionally	1	
	Not at all	0	
I still enjoy the things I used to enjoy:	Definitely as much	0	D
	Not quite so much	1	
	Only a little	2	
	Hardly at all	3	
I get a sort of frightened feeling as if something awful is about to happen:	Very definitely and quite badly	3	A
	Yes, but not too badly	2	
	A little, but it doesn't worry me	1	
	Not at all	0	
I can laugh and see the funny side of things:	As much as I always could	0	D
	Not quite so much now	1	
	Definitely not so much now	2	
	Not at all	3	
Worrying thoughts go through my mind:	A great deal of the time	3	A
	A lot of the time	2	
	From time to time, but not too often	1	
	Only occasionally	0	
I feel cheerful:	Not at all	3	D
	Not often	2	
	Sometimes	1	
	Most of the time	0	
I can sit at ease and feel relaxed:	Definitely	0	A
	Usually	1	
	Not Often	2	
	Not at all	3	

I feel as if I am slowed down	Nearly all the time	3	D
	Very often	2	
	Sometimes	1	
	Not at all	0	
I get a sort of frightened feeling like 'butterflies' in the stomach:	Not at all	0	A
	Occasionally	1	
	Quite Often	2	
	Very Often	3	
I have lost interest in my appearance:	Definitely	3	D
	I don't take as much care as I should	2	
	I may not take quite as much care	1	
	I take just as much care as ever	0	
I feel restless as I have to be on the move:	Very much indeed	3	A
	Quite a lot	2	
	Not very much	1	
	Not at all	0	
I look forward with enjoyment to things:	As much as I ever did	0	D
	Rather less than I used to	1	
	Definitely less than I used to	2	
	Hardly at all	3	
I get sudden feelings of panic:	Very often indeed	3	A
	Quite often	2	
	Not very often	1	
	Not at all	0	
I can enjoy a good book or radio or TV program:	Often	0	D
	Sometimes	1	
	Not often	2	
	Very seldom	3	

7. Economic impact		
7.01	Think back over the past 12 months. Have any of these happened to your household on at least one occasion because you were short of money? <i>(tick all that apply)</i>	<p>Could not pay for:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Gas, electricity, phone bills</li> <li><input type="checkbox"/> Rent or mortgage</li> <li><input type="checkbox"/> Medicines/drugs</li> <li><input type="checkbox"/> Medical consultations or tests</li> <li><input type="checkbox"/> Health insurance</li> <li><input type="checkbox"/> School fees for children</li> <li><input type="checkbox"/> Transport costs</li> <li><input type="checkbox"/> Meals</li> </ul> <p>Did not:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Attend medical appointments</li> <li><input type="checkbox"/> Buy medicines/drugs</li> </ul>
7.02	Did your household do any of these things because you needed money for living expenses in the past 12 months? <i>(tick all that apply)</i>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Moved house</li> <li><input type="checkbox"/> Used savings that has been put aside for another use</li> <li><input type="checkbox"/> Asked for financial assistance from friends or family</li> <li><input type="checkbox"/> Asked for financial assistance from a government or community organisation</li> <li><input type="checkbox"/> Took out a personal loan</li> <li><input type="checkbox"/> Sold assets / other property</li> </ul>
7.03	How would you say you (and your family) were getting on financially, over the past 12 months? <i>(please tick only one)</i>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Prosperous</li> <li><input type="checkbox"/> Reasonably comfortable</li> <li><input type="checkbox"/> Just getting on</li> </ul>

		<input type="checkbox"/> Poor <input type="checkbox"/> Very poor <input type="checkbox"/> Don't know
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## 8. Need for assistance

The following questions are about any assistance you receive from family members or friends because of your health:

8.01 Do you usually need regular help with the following daily tasks?							
				If yes, who provides this help?			
		YES	NO	Spouse/ partner	Child(ren)	Outside help	Other
Personal care (bathing, using the toilet, brushing teeth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting around (walking, running errands, getting in and out of car)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household and garden maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work on your land	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bring children to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.02	On average, how many hours a day do you receive help?			_ _  hours			
8.03	Who provides most help?			<input type="checkbox"/> Spouse/partner <input type="checkbox"/> Child(ren) <input type="checkbox"/> Outside paid help <input type="checkbox"/> Other			
8.04	Has this carer's involvement in your care affected his or her: <i>(tick all that apply)</i>			<input type="checkbox"/> Employment (i.e. has he or she had to stop working or reduce the number of hours of paid work per			

		week)? <input type="checkbox"/> Education (i.e. has he or she had to stop school or reduce the number of hours attending school each week)? <input type="checkbox"/> Friendships or ability to participate in social activities?
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9. Cost diary		
9.01	Cost diary provided to participant with explanation	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.02	If not, please provide reason	

10. Signature of person completing the form		
10.01	Signature	_____
10.02	Date form signed	__ __   __ __   20__ __