

QUESTIONNAIRE

Funded by

National Institute for
Health Research

Introduction to the questionnaire

Keele University are doing a research study about depression and anxiety in older adults. We are interested in finding out about YOU and YOUR experiences.

The following pages ask you a range of questions about your health and well-being, your feelings and your emotions.

We understand that it is not always easy to choose an option that describes exactly what you are feeling, and if you are unsure which response to give, please choose the response that comes closest to how you feel.

Please choose ONE response from the options provided. Please answer all of the questions, there are no right or wrong answers. The answers that you do give will be treated in the **strictest confidence**.

Please return this booklet to us in the **pre-paid** envelope provided. **You do not need a stamp.**

If you would like further information, or have any questions about this research, please contact a member of the NOTEPAD research team at Keele University by telephone on [REDACTED] or by email at [REDACTED].

Thank you for your help with this research study

SECTION A. Questions about your mood

(PHQ-9)

Please choose ONE answer for each question and mark with a 'X'

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
1. Little interest or pleasure in doing things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Trouble concentrating on things, such as reading the newspaper or watching television.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Thoughts that you would be better off dead or of hurting yourself in some way.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B. Questions about your stress (GAD-7)

Please choose ONE answer and mark with a 'X'

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
1. Feeling nervous, anxious or on edge.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.	Trouble relaxing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Being so restless that it is hard to sit still.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Becoming easily annoyed or irritable.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Feeling afraid as if something awful might happen.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION C. Questions about you


1. Are you: Male..... Female.....

2. What is your date of birth?(dd/mm/yyyy)

Thank you for taking the time to answer these questions.

Please complete the consent to contact form over the page and return this booklet in the prepaid envelope provided (you do not need a stamp).

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ID Label: 



The NOTEPAD research study: Consent to contact

Thank you for completing this questionnaire. By completing this questionnaire, I confirm that I have read the enclosed Participant Information Sheet (Version 2.0, 18/08/2016) and would be happy for a member of the NOTEPAD research team to contact me to discuss the study further.

Please complete the following details:

Title: Forename: Surname:

Address:

Post code:

Telephone numbers:

Home:

Mobile:

Email address:

The most convenient time to contact me is (please tick your choice):

Morning

Afternoon

Evening

Anytime

Please return this questionnaire in the pre-paid envelope provided.

If you have any queries please contact a member of the NOTEPAD research team at Keele University by telephone on [REDACTED] or by email at [REDACTED]

ID Label: