In Confidence

Aesops

Baseline Questionnaire

Office use only (for designated person to complete)

Practice ID:	
Date AUDIT Completed:	day month year

PLEASE READ ALL THE INSTRUCTIONS BEFORE COMPLETING THE QUESTIONNAIRE				
Thank you for agreeing to complete this questionnaire.				
The responses you give in this questionnaire will help us understand the relationship between drinking and health. Please read each section carefully. Please answer all the questions. Although some questions appear similar, it is still important that you answer every one. If you find it difficult to answer a question, please give the best answer that you can.				
Please follow the instructions for each question carefully.				
For each question you will be asked to put a cross in the box.				
For example in the following question, if your answer to the question was 'Yes', you should place a cross in the box next to 'Yes'.				
Do you drive a car ? Yes				
Do you drive a car ? Yes No				
Please use a black or blue pen. Please do not use a pencil or any other coloured pen.				

This section asks about the alcohol you have drunk in the past 6 months. The questions ask about how many **standard drinks** you have consumed. A description of a standard drink is given in the box below.



Please answer each question by placing a cross in the box. Please only cross one box for each question.

1.	How often do yo	ou have a drink	containing alco	hol?		
	Never	Monthly	2 to 4 times	2 to 3 times	4 to 5 times a	6 or more
		or less	a month	a week	week	times a week
2.	How many stan	dard drinks c	ontaining alcoho	l do you drink o	n a typical day y	ou are drinking?
	None	1 to 2	3 to 4	5 to 6	7 to 9	10 or more
3.	How often have	you had 6 or r	more standard d	Irinks on a sing	le occasion in th	e past 6 months?
		Less than monthly	Monthly	Weekly	Daily or almost daily	
4.	Compared with	n six months a	ago, how much a	alcohol do you d	Irink in a typical v	week?
	Much less than 6 months ago		men / moent n			lot more than 6 months ago

The following questions ask about any problems you have experienced related to drinking alcohol. Please answer each question by placing a cross in the box. If you do not drink alcohol please cross the 'Never' box for each question.

In the past 6 months how often have you....

	Never	Once or twice	Occasionally	Fairly often	Often
Been drunk after drinking					
Had a fall or accident after drinking					
Felt confused after drinking					
Had a friend worry or complain about your drinking					
Neglected your appearance because of your drinking					
Had problems occur between you and a member of your family because of your drinking					
Gone to anyone for help about your drinking					
Neglected your work because of your drinking					
Lost friends because of your drinking					
Become intoxicated or drunk after drinking					
Skipped meals because of your drinking					
Had a family member worry or complain about your drinking					
Felt you were spending too much money on drink					
Felt isolated from people because of your drinking					
Had a drink to help you forget your worries					
Had a craving for a drink the first thing after you woke up					
Neglected the appearance of your living quarters because of your drinking					

This section asks for your views about your health. This section will help us keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1.	In general, would (please cross one		ealth is:		
	Excellent	Very Good	Good	Fair	Poor
2.		acuum cleaner,	ealth limit you in mod bowling or playing g		
	Yes, limited a lot	t Ye:	s, limited a little	No, not limite	ed at all
3.	During a typical d much ? (please cross one		ealth limit you in clim	bing several flight	s of stairs ? If so, how
	Yes, limited a lot	t Ye	s, limited a little	No, not limite	ed at all
4.		ly activities as a	ich of the time have y result of your phys		less than you would
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
5.		ily activities as a	ich of the time have y result of your phys		n performing any
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
6.	would have liked	in your work or a ems (such as fe	ich of the time have y any other regular dail eling depressed or a	y activities as a re	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time

7.		ual as a result of		you done work or oblems (such as fe	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
8.		e and housework)		e with your normal	work (both
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9.	How much during (please cross on	_	have you felt calm	and peaceful ?	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
10.	. How much during (please cross on	-	did you have a lot o	of energy ?	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
11.	. How much during (please cross on	-	have you felt down	hearted and depres	ssed?
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
12.		ered with your soci		our physical healt siting friends, relati	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time

This section also asks about your health in general. By placing a cross in one box in each group below, please indicate which statement best describes your health state today.

Place a cross in one box in each group.

1.	Mobility	
	I have no problems in walking about	
	I have some problems in walking about	
	I am confined to bed	
2.	Self-care	
	I have no problems with self-care	
	I have some problems washing or dressing myself	\Box
	I am unable to wash or dress myself	
3.	Usual activities (e.g. work, study, housework, family or leisure activities)	
	I have no problems with performing my usual activities	
	I have some problems with performing my usual activities	
	I am unable to perform my usual activities	
4.	Pain or discomfort	
	I have no pain or discomfort	
	I have moderate pain or discomfort	
	I have extreme pain or discomfort	
5.	Anxiety or depression	
	I am not anxious or depressed	
	I am moderately anxious or depressed	
	I am extremely anxious or depressed	

This section asks about your use of health and social resources in the past 6 months. Please read each question carefully and remember each question relates to the **past 6 months only**. If your answer is 'none', please enter 'zero' in the box.

Hospital and Primary Health Care Services

1.	In the past 6 months how many times have you visited an accident and emergency department as a patient?	
2.	In the past 6 months how many nights have you spent in hospital as an inpatient?	
3.	In the past 6 months how many times have you attended hospital as an outpatient?	
4.	In the past 6 months how many times have you attended a day hospital? (i.e. you have been admitted to hospital but not kept in overnight)	
5.	In the past 6 months how many times have you been taken to hospital in an emergency ambulance?	
6.	In the past 6 months how many times have you been taken to or from hospital using a patient transport service?	
7.	In the past 6 months how many times have you visited a doctor at your GP practice?	
8.	In the past 6 months how many times has a doctor visited you at home?	
9.	In the past 6 months how many times have you visited the nurse at your GP practice?	
10.	In the past 6 months how many times has a nurse visited you at home?	
11	How many times have you received a prescription in the past 6 months?	
12.	In the past 6 months have you visited any other health care professional other than a doctor or nurse at your GP surgery?	
	Professional visited	Number of visits
		$\overline{}$
13.	In the past 6 months has any other health care professional other than a doctor or nurse visited you at home?	
	Professional who has visited you	Number of visits
		HH

Social and Care Services

1.	if so, how many times?	e you used any or the following services a	ind
		Community/Day Centres	
		Meals on Wheels	
		Social Services Home Care Services	
2.	In the past 6 months how social worker at home?	many times have you been visited by a	
3.	In the past 6 months how worker at their office?	many times have you visited a social	
4.	In the past 6 months how worker or advisor at their of	many times have you visited a care office?	
5.	In the past 6 months how home by a care worker or	many times have you been visited at advisor?	
<u>Po</u>	lice and Criminal Justice	System Contacts	
1.	In the past 6 months how cautioned or received an o	many times have you been arrested, on-the-spot fine?	
2.	Have you appeared in cou	ort in the past 6 months?	Yes No
	If yes how many times?		
		Magistrates Court (days)	
		Crown Court (times)	
3.	Have you been in prison in	n the past 6 months?	Yes No
	If yes how many days in	total?	
		Number of days	

	Section 6					
1.	What is your age in years?					
2.	Are you?	M	ale		Female	
3.	Are you?			A current	tsmoke	r 🗌
				An ex-sn	noker	
				A never	smoker	
4.	Which of the following best describes your main acti	ivity?				
		In employm	ent o	r self emp	loymen	t 🔙
		Retired				
		Housework				
		Student				\Box
		Seeking Wo	ork			\Box
		Other				\Box
		(If 'Other', p	lease	specify I	pelow)	Ш.
5.	Which of the following best describes your living arra	angements?		Sir	igle	
				Ма	rried	
				Co	-habiting	9
				Wi	dowed	
6.	Which of the following best describes your current a	ccommodati	on?			
		(Owne	r occupie	d	
		F	Privat	te rented		
		l	LA/Ho	ousing as	sociation	n 🗌
		1	Temp	orary		
7.	Did your education continue after the minimum scholeaving age?	ool	Yes	s 🗌	No	
8.	Do you have a Degree or equivalent professional qualification?		Yes	s 🗌	No	

9.	Are you willing to be contacted regarding participation in this research study?	Yes	No
lf y	ou have any comments you would like to add, please use the sp	pace below.	

In Confidence

Aesops

Six Month Questionnaire

Office use only (for designated person to complete)

Practice ID:	
Date AUDIT Completed:	day month year

PLEASE READ ALL THE INSTRUCTIONS BEFORE COMPLETING THE QUESTIONNAIRE							
Thank you for agreeing to complete this questionnaire.							
The responses you give in this questionnaire will help us understand the relationship between drinking and health. Please read each section carefully. Please answer all the questions. Although some questions appear similar, it is still important that you answer every one. If you find it difficult to answer a question, please give the best answer that you can.							
Please follow the instructions for each question carefully.							
For each question you will be asked to put a cross in the box.							
For example in the following question, if your answer to the question was 'Yes', you should place a cross in the box next to 'Yes'.							
Do you drive a car ? Yes							
Do you drive a car? Yes No							
Please use a black or blue pen. Please do not use a pencil or any other coloured pen.							

This section asks about the alcohol you have drunk in the past 6 months. The questions ask about how many standard drinks you have consumed. A description of a standard drink is given in the box below.



Please answer each question by placing a cross in the box. Please only cross one box for each question.

1.	. How often do you have a drink containing alcohol ?					
	Never	Monthly	2 to 4 times	2 to 3 times		
		or less	a month	a week	week	times a week
2.	How many star	ndard drinks c	ontaining alcoh	ol do you drink	on a typical day	you are drinking?
	None	1 to 2	3 to 4	5 to 6	7 to 9	10 or more
3.	How often have	you had 6 or i	more standard	drinks on a sir	ngle occasion in t	he past 6 months?
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4.	Compared wit	h six months	ago, how much	alcohol do you	drink in a typical	week?
	Much less than 6 months ago					A lot more than 6 months ago
			[

The following questions ask about any problems you have experienced related to drinking alcohol. Please answer each question by placing a cross in the box. If you do not drink alcohol please cross the 'Never' box for each question.

In the past 6 months how often have you....

	Never	Once or twice	Occasionally	Fairly often	Often
Been drunk after drinking					
Had a fall or accident after drinking					
Felt confused after drinking					
Had a friend worry or complain about your drinking					
Neglected your appearance because of your drinking					
Had problems occur between you and a member of your family because of your drinking					
Gone to anyone for help about your drinking					
Neglected your work because of your drinking					
Lost friends because of your drinking					
Become intoxicated or drunk after drinking					
Skipped meals because of your drinking					
Had a family member worry or complain about your drinking					
Felt you were spending too much money on drink					
Felt isolated from people because of your drinking					
Had a drink to help you forget your worries					
Had a craving for a drink the first thing after you woke up					
Neglected the appearance of your living quarters because of your drinking					

This section asks for your views about your health. This section will help us keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1.	In general, would (please cross one		alth is:		
	Excellent	Very Good	Good	Fair	Poor
2.		vacuum cleaner,	ealth limit you in moo bowling or playing g		_
	Yes, limited a lo	t Yes	s, limited a little	No, not limite	ed at all
3.	During a typical d much ? (please cross one		alth limit you in clim	bing several fligh	ts of stairs ? If so, hov
	Yes, limited a lo	t Yes	s, limited a little	No, not limite	ed at all
4.		ly activities as a	ch of the time have result of your phys		less than you would
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
5.		aily activities as a	ch of the time have result of your phy	-	n performing any
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
6.	would have liked	in your work or a ems (such as fee	ch of the time have my other regular dail eling depressed or a	y activities as a re	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time

7.	7. During the past 4 weeks, how much of the time have you done work or other activities to carefully than usual as a result of any emotional problems (such as feeling depresse anxious)? (please cross one box only)					
	All of the time	Most of the time	Some of the time	A little of the time	None of the time	
8.	During the past 4 outside the home (please cross one	and housework)		e with your normal	work (both	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time	
	ume		the time	the time	the time	
9.	How much during (please cross one		ave you felt calm	and peaceful ?		
	All of the time	Most of	Some of	A little of	None of	
	ume	the time	the time	the time	the time	
10.	How much during (please cross one		id you have a lot o	of energy ?		
	All of the	Most of	Some of	A little of	None of	
	time	the time	the time	the time	the time	
11.	How much during (please cross one		ave you felt down	hearted and depres	ssed ?	
	All of the	Most of	Some of	A little of	None of	
	time	the time	the time	the time	the time	
12.		ed with your socia		our physical healt l siting friends, relativ		
	All of the	Most of	Some of	A little of	None of	
	time	the time	the time	the time	the time	
	1 1	1 1	1 1	1 1		

This section also asks about your health in general. By placing a cross in one box in each group below, please indicate which statement best describes your health state today.

Place a cross in one box in each group.

1.	Mobility	
	I have no problems in walking about	
	I have some problems in walking about	
	I am confined to bed	
2.	Self-care	
	I have no problems with self-care	
	I have some problems washing or dressing myself	
	I am unable to wash or dress myself	
3.	Usual activities (e.g. work, study, housework, family or leisure activities)	
	I have no problems with performing my usual activities	
	I have some problems with performing my usual activities	
	I am unable to perform my usual activities	
4.	Pain or discomfort	
	I have no pain or discomfort	
	I have moderate pain or discomfort	
	I have extreme pain or discomfort	
5.	Anxiety or depression	
	I am not anxious or depressed	
	I am moderately anxious or depressed	
	I am extremely anxious or depressed	

This section asks about your use of health and social resources in the past 6 months. Please read each question carefully and remember each question relates to the **past 6** months only. If your answer is 'none', please enter '0' in the box.

Hospital and Primary Health Care Services

1.	In the past 6 months how many times have you visited an accident and emergency department as a patient?	
2.	In the past 6 months how many nights have you spent in hospital as an inpatient?	
3.	In the past 6 months how many times have you attended hospital as an outpatient?	
4.	In the past 6 months how many times have you attended a day hospital? (i.e. you have been admitted to hospital but not kept in overnight)	
5.	In the past 6 months how many times have you been taken to hospital in an emergency ambulance?	
6.	In the past 6 months how many times have you been taken to or from hospital using a patient transport service?	
7.	In the past 6 months how many times have you visited a doctor at your GP practice?	
8.	In the past 6 months how many times has a doctor visited you at home?	
9.	In the past 6 months how many times have you visited the nurse at your GP practice?	
10.	In the past 6 months how many times has a nurse visited you at home?	
11	How many times have you received a prescription in the past 6 months?	
12.	In the past 6 months have you visited any other health care professional other than a doctor or nurse at your GP surgery?	
	Professional visited	Number of visits
13.	In the past 6 months has any other health care professional other than a doctor or nurse visited you at home?	
	Professional who has visited you	Number of visits

Social and Care Services

١.	if so, how many times?	services and	
	Community/Day Centres		
	Meals on Wheels		
	Social Services Home Care S	ervices	
2.	In the past 6 months how many times have you been visuoial worker at home?	sited by a	
3.	In the past 6 months how many times have you visited a worker at their office?	a social	
4.	In the past 6 months how many times have you visited a worker or advisor at their office?	a care	
5.	i. In the past 6 months how many times have you been vis home by a care worker or advisor?	sited at	
Po	Police and Criminal Justice System Contacts		
1.	In the past 6 months how many times have you been ar cautioned or received an on-the-spot fine?	rested,	
2.	2. Have you appeared in court in the past 6 months?	Ye	s No
	If yes how many times?		
	Magistrates Court (days)		
	Crown Court (times)		
3.	3. Have you been in prison in the past 6 months?	Ye	s No
	If yes how many days in total?		
	Number of days		

If you have any comments you would like to add, please use the space below.					

In Confidence

Aesops

Twelve Month Questionnaire

Office use only (for designated person to complete)

Practice ID:	
Date:	day month year

PLEASE READ ALL THE INSTRUCTIONS BEFORE COMPLETING THE QUESTIONNAIRE						
Thank you for agreeing to complete this questionnaire.						
The responses you give in this questionnaire will help us understand the relationship between drinking and health. Please read each section carefully. Please answer all the questions. Although some questions appear similar, it is still important that you answer every one. If you find it difficult to answer a question, please give the best answer that you can.						
Please follow the instructions for each question carefully.						
For each question you will be asked to put a cross in the box.						
For example in the following question, if your answer to the question was 'Yes', you should place a cross in the box next to 'Yes'.						
Do you drive a car ? Yes No						
No						
Please use a black or blue pen. Please do not use a pencil or any other coloured pen.						

This section asks about the alcohol you have drunk in the past 6 months. The questions ask about how many **standard drinks** you have consumed. A description of a standard drink is given in the box below.



Please answer each question by placing a cross in the box. Please only cross one box for each question.

1.	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 to 5 times a week	6 or more times a week
2.	How many stan	dard drinks co	ontaining alcoho	l do you drink o	n a typical day y	ou are drinking?
	None	1 to 2	3 to 4	5 to 6	7 to 9	10 or more
3.	How often have	you had 6 or n	nore standard d	Irinks on a sing	le occasion in th	ne past 6 months?
		ess than monthly	Monthly	Weekly	Daily or almost daily	
4.	Compared with	six months a	go, how much a	alcohol do you d	rink in a typical	week?
	Much less than 6 months ago		han About th ago as 6 moi			lot more than 6 months ago

The following questions ask about any problems you have experienced related to drinking alcohol. Please answer each question by placing a cross in the box. If you do not drink alcohol please cross the 'Never' box for each question.

In the past 6 months how often have you....

	Never	Once or twice	Occasionally	Fairly often	Often
Been drunk after drinking					
Had a fall or accident after drinking					
Felt confused after drinking					
Had a friend worry or complain about your drinking					
Neglected your appearance because of your drinking					
Had problems occur between you and a member of your family because of your drinking					
Gone to anyone for help about your drinking					
Neglected your work because of your drinking					
Lost friends because of your drinking					
Become intoxicated or drunk after drinking					
Skipped meals because of your drinking					
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Felt you were spending too much money on drink					
Felt isolated from people because of your drinking					
Had a drink to help you forget your worries					
Had a craving for a drink the first thing after you woke up					
Neglected the appearance of your living quarters because of your drinking					

This section asks for your views about your health. This section will help us keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1.	(please cross one box only)					
	Excellent	Very Good	Good	Fair	Poor	
2.		vacuum cleaner,	alth limit you in mo bowling or playing o		_	
	Yes, limited a lo	t Yes	, limited a little	No, not limite	ed at all	
3.	During a typical of much ? (please cross one	-	alth limit you in clin	nbing several flight	s of stairs? If so, how	
	Yes, limited a lo	t Yes	s, limited a little	No, not limite	ed at all	
4.		ily activities as a	ch of the time have result of your phys		less than you would	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time	
5.		aily activities as a	ch of the time have result of your phy	-	n performing any	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time	
6.	would have liked	in your work or a ems (such as fee	ch of the time have ny other regular dai ling depressed or a	ily activities as a re		
	All of the time	Most of the time	Some of the time	A little of the time	None of the time	

7.		al as a result of			other activities less eeling depressed or
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
8.	During the past 4 outside the home (please cross one	and housework)		e with your normal	work (both
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9.	How much during (please cross one		nave you felt calm	and peaceful ?	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
10.	How much during (please cross one		did you have a lot o	of energy ?	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
11.	How much during (please cross one		nave you felt down	hearted and depres	ssed ?
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
12.		red with your soci		our physical healt siting friends, relati	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time

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Place a cross in one box in each group.

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	I am confined to bed	
2.	Self-care	
	I have no problems with self-care	
	I have some problems washing or dressing myself	
	I am unable to wash or dress myself	
3.	Usual activities (e.g. work, study, housework, family or leisure activities)	
	I have no problems with performing my usual activities	
	I have some problems with performing my usual activities	
	I am unable to perform my usual activities	
4.	Pain or discomfort	
	I have no pain or discomfort	
	I have moderate pain or discomfort	
	I have extreme pain or discomfort	
5.	Anxiety or depression	
	I am not anxious or depressed	
	I am moderately anxious or depressed	
	I am extremely anxious or depressed	

This section asks about your use of health and social resources in the past 6 months. Please read each question carefully and remember each question relates to the **past 6 months only**. If your answer is 'none', please enter '0' in the box.

Hospital and Primary Health Care Services

1.	In the past 6 months how many times have you visited an accident and emergency department as a patient?	
2.	In the past 6 months how many nights have you spent in hospital as an inpatient?	
3.	In the past 6 months how many times have you attended hospital as an outpatient?	
4.	In the past 6 months how many times have you attended a day hospital? (i.e. you have been admitted to hospital but not kept in overnight)	
5.	In the past 6 months how many times have you been taken to hospital in an emergency ambulance?	
6.	In the past 6 months how many times have you been taken to or from hospital using a patient transport service?	
7.	In the past 6 months how many times have you visited a doctor at your GP practice?	
8.	In the past 6 months how many times has a doctor visited you at home?	
9.	In the past 6 months how many times have you visited the nurse at your GP practice?	
10.	In the past 6 months how many times has a nurse visited you at home?	
11	How many times have you received a prescription in the past 6 months?	
12.	In the past 6 months have you visited any other health care professional other than a doctor or nurse at your GP surgery?	
	Professional visited	Number of visits
13.	In the past 6 months has any other health care professional other than a doctor or nurse visited you at home?	
	Professional who has visited you	Number of visits

Social and Care Services

١.	if so, how many times?	e you used any or the following services a	nu .
		Community/Day Centres	
		Meals on Wheels	
		Social Services Home Care Services	
2.	In the past 6 months how social worker at home?	many times have you been visited by a	
3.	In the past 6 months how worker at their office?	many times have you visited a social	
4.	In the past 6 months how worker or advisor at their	many times have you visited a care office?	
5.	In the past 6 months how home by a care worker or	many times have you been visited at advisor?	
Po	lice and Criminal Justice	System Contacts	
1.	In the past 6 months how cautioned or received an	many times have you been arrested, on-the-spot fine?	
2.	Have you appeared in cou	irt in the past 6 months?	Yes No
	If yes how many times?		
		Magistrates Court (days)	
		Crown Court (times)	
3.	Have you been in prison i	n the past 6 months?	Yes No
	If yes how many days in	total?	
		Number of days	

If you have any comments you would like to add, please use the space below.					

In Confidence

Aesops

Non Participant Questionnaire

Office use only (for designated person to complete)

Practice ID:	
A_Score:	
Date AUDIT Completed:	day month year

PLEASE READ ALL THE INSTRUCTIONS BEFORE COMPLETING THE QUESTIONNAIRE

Thank you for agreeing to complete this questionnaire. We will only ask you to complete this questionnaire. The questionnaire contains no information that can identify you.

The responses you give in this questionnaire will help us understand the relationship between drinking and health. Please read each section carefully. Please answer all the questions. Although some questions appear similar, it is still important that you answer every one. If you find it difficult to answer a question, please give the best answer that you can.

Please follow the instructions for each question carefully.

For each question you will be asked to put a cross in the box.

For example in the following question, if your answer to the question was 'Yes', you should place a cross in the box next to 'Yes'.

Do you drive a car? Yes

Please use a black or blue pen. Please do not use a pencil or any other coloured pen.

This section asks about the alcohol you have drunk in the past 6 months. The questions ask about how many standard drinks you have consumed. A description of a standard drink is given in the box below.



Please answer each question by placing a cross in the box. Please only cross one box for each question.

1.	How often do y	ou have a drink	containing alcol	hol?		
	Never	Monthly	2 to 4 times	2 to 3 times	4 to 5 times a	
		or less	a month	a week	week	times a week
2.	How many star	ndard drinks co	ontaining alcoho	l do you drink o	n a typical day y	you are drinking?
	None	1 to 2	3 to 4	5 to 6	7 to 9	10 or more
3.	How often have	you had 6 or n	nore standard d	Irinks on a sing	le occasion in t	he past 6 months?
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4.	Compared with	h six months a	ngo, how much a	alcohol do you d	Irink in a typical	week?
	Much less than 6 months ago					A lot more than 6 months ago

The following questions ask about any problems you have experienced related to drinking alcohol. Please answer each question by placing a cross in the box. If you do not drink alcohol please cross the 'Never' box for each question.

In the past 6 months how often have you....

	Never	Once or twice	Occasionally	Fairly often	Often
Been drunk after drinking					
Had a fall or accident after drinking					
Felt confused after drinking					
Had a friend worry or complain about your drinking					
Neglected your appearance because of your drinking					
Had problems occur between you and a member of your family because of your drinking					
Gone to anyone for help about your drinking					
Neglected your work because of your drinking					
Lost friends because of your drinking					
Become intoxicated or drunk after drinking					
Skipped meals because of your drinking					
Had a family member worry or complain about your drinking					
Felt you were spending too much money on drink					
Felt isolated from people because of your drinking					
Had a drink to help you forget your worries					
Had a craving for a drink the first thing after you woke up					
Neglected the appearance of your living quarters because of your drinking					

This section asks for your views about your health. This section will help us keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1.	In general, would (please cross on		alth is:		
	Excellent	Very Good	Good	Fair	Poor
2.		vacuum cleaner,	ealth limit you in mo bowling or playing g		
	Yes, limited a lo	t Yes	s, limited a little	No, not limite	ed at all
3.	During a typical omuch ? (please cross on		ealth limit you in clim	nbing several flight	s of stairs ? If so, how
	Yes, limited a lo	t Yes	s, limited a little	No, not limite	ed at all
4.	- '	ily activities as a	ch of the time have result of your phys		less than you would
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
5.		aily activities as a	ch of the time have result of your phy		performing any
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
6.	would have liked	l in your work or a lems (such as fee	ich of the time have iny other regular dai eling depressed or a	ly activities as a re	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time

7. During the past 4 weeks, how much of the time have you done work or other a carefully than usual as a result of any emotional problems (such as feeling anxious)? (please cross one box only)					
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
8.	During the past 4 outside the home (please cross one	and housework) ?		e with your normal	work (both
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9.	How much during (please cross one		ave you felt calm	and peaceful ?	
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
10.	How much during (please cross one		id you have a lot o	of energy?	
	All of the	Most of	Some of	A little of	None of
	time	the time	the time	the time	the time
11.	How much during (please cross one		ave you felt down	hearted and depres	ssed ?
	All of the	Most of	Some of	A little of	None of
	time	the time	the time	the time	the time
12.	During the past 4 problems interfere (please cross one	ed with your socia		our physical health siting friends, relativ	
	All of the	Most of	Some of	A little of	None of
	time	the time	the time	the time	the time
	1 1	1 1	1 1	1 1	1 1

This section also asks about your health in general. By placing a cross in one box in each group below, please indicate which statement best describes your health state today.

Place a cross in one box in each group.

1.	Mobility	
	I have no problems in walking about	
	I have some problems in walking about	
	I am confined to bed	
2.	Self-care	
	I have no problems with self-care	
	I have some problems washing or dressing myself	
	I am unable to wash or dress myself	
3.	Usual activities (e.g. work, study, housework, family or leisure activities)	
	I have no problems with performing my usual activities	
	I have some problems with performing my usual activities	
	I am unable to perform my usual activities	
4.	Pain or discomfort	
	I have no pain or discomfort	
	I have moderate pain or discomfort	
	I have extreme pain or discomfort	
5.	Anxiety or depression	
	I am not anxious or depressed	
	I am moderately anxious or depressed	
	I am extremely anxious or depressed	

This section asks about your use of health and social resources in the past 6 months. Please read each question carefully and remember each question relates to the **past 6** months only. If your answer is 'none', please enter 'zero' in the box.

Hospital and Primary Health Care Services

1.	In the past 6 months how many times have you visited an accident and emergency department as a patient?	
2.	In the past 6 months how many nights have you spent in hospital as an inpatient?	
3.	In the past 6 months how many times have you attended hospital as an outpatient?	
4.	In the past 6 months how many times have you attended a day hospital? (i.e. you have been admitted to hospital but not kept in overnight)	
5.	In the past 6 months how many times have you been taken to hospital in an emergency ambulance?	
6.	In the past 6 months how many times have you been taken to or from hospital using a patient transport service?	
7.	In the past 6 months how many times have you visited a doctor at your GP practice?	
8.	In the past 6 months how many times has a doctor visited you at home?	
9.	In the past 6 months how many times have you visited the nurse at your GP practice?	
10.	In the past 6 months how many times has a nurse visited you at home?	
11	How many times have you received a prescription in the past 6 months?	
12.	In the past 6 months have you visited any other health care professional other than a doctor or nurse at your GP surgery?	
	Professional visited	Number of visits
13.	In the past 6 months has any other health care professional other than a doctor or nurse visited you at home?	
	Professional who has visited you	Number of visits

Social and Care Services

١.	and if so, how many times?	•
	Community/Day Centres	
	Meals on Wheels	
	Social Services Home Care Services	
2.	In the past 6 months how many times have you been visited by a social worker at home?	
3.	In the past 6 months how many times have you visited a social worker at their office?	
4.	In the past 6 months how many times have you visited a care worker or advisor at their office?	
5.	In the past 6 months how many times have you been visited at home by a care worker or advisor?	
Po	olice and Criminal Justice System Contacts	
1.	In the past 6 months how many times have you been arrested, cautioned or received an on-the-spot fine?	
2.	Have you appeared in court in the past 6 months?	Yes No
	If yes how many times?	
	Magistrates Court (days)	
	Crown Court (times)	
3.	Have you been in prison in the past 6 months?	Yes No
	If yes how many days in total?	
	Number of days	

	Section 6					
1.	What is your age in years?					
2.	Are you?	N	Лаle		Female	
3.	Are you?			A currer	it smoker	
				An ex-si	moker	
				A never	smoker	
4.	Which of the following best describes your main act	tivity?				
		In employr	nent o	r self em	ployment	
		Retired				
		Housework	k			
		Student				
		Seeking W	/ork			
		Other				
		(If 'Other',	pleas	e specify	below)	
5.	Which of the following best describes your living arr	rangements	?	Si	ngle	
				M	arried	
				Co	o-habiting	, _
				W	idowed	$\overline{\Box}$
6.	Which of the following best describes your current a	accommoda	tion?			
			Owne	er occupi	ed	
			Priva	te rented		
			LA/H	ousing as	sociation	
			Temp	oorary		
7.	Did your education continue after the minimum scholeaving age?	ool	Ye	s	No	
8.	Do you have a Degree or equivalent professional qualification?		Ye	s	No	

If you have any comments you would like to add, please use the space below.			