CONFIDENTIAL

Baseline Questionnaire

Participant's trial ID number: ☐☐ - ☐☐☐☐☐

Date questionnaire sent: ☐☐ / ☐☐ / 2 0 ☐☐

Day Month Year

Funded by:

Organised by:

The University of York

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CASPER baseline qr v2.5 4Jan13

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PLEASE READ ALL THE INSTRUCTIONS BEFORE COMPLETING THE QUESTIONNAIRE

Thank you for agreeing to take part in this study. The responses you give in this questionnaire will help us find out which is the best way to improve mental well-being amongst those over the age of 65.

Please answer ALL the questions. Although some of the questions may not seem relevant to yourself or may appear similar, they do give us valuable information.

If you find it difficult to answer the question, please give the best answer you can.

Please follow the instructions for each section carefully.

For each section, if you are asked to put a cross in the box, please use a cross rather than a tick, as if you were filling out a ballot paper.

For example in the following question, if your answer to the question is yes, you should place a cross firmly in the box next to yes.

Do you drive a car?

Yes ☒

No ☐

If you are asked to write your answer, please do so by entering your answer in the box provided, for example:

How old are you? | 7 | 5 | years

Please use a black or blue pen for all the questions.

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

If you have any queries or problems completing this questionnaire please contact your local study centre:

Dr Helen Lewis
CASPER Trial Coordinaor

Phone:
E-mail:

Please enter the date you are completing this questionnaire:

	/		/	2 0 _ _
Day		*Month*		*Year*

SECTION 1

This section is about how you have been feeling over the **last 2 weeks**.
Answer each question by placing a cross in the box that best describes your answer.

1. Little interest or pleasure in doing things

Not at all ☐ | Several days ☐ | More than half the days ☐ | Nearly every day ☐

2. Feeling down, depressed, or hopeless

Not at all ☐ | Several days ☐ | More than half the days ☐ | Nearly every day ☐

3. Trouble falling or staying asleep, or sleeping too much

Not at all ☐ | Several days ☐ | More than half the days ☐ | Nearly every day ☐

4. Feeling tired or having little energy

Not at all ☐ | Several days ☐ | More than half the days ☐ | Nearly every day ☐

5. Poor appetite or overeating

Not at all ☐ | Several days ☐ | More than half the days ☐ | Nearly every day ☐

6. Feeling bad about yourself - that you are a failure or have let yourself or your family down

Not at all ☐ | Several days ☐ | More than half the days ☐ | Nearly every day ☐

7. Trouble concentrating on things, such as reading the newspaper or watching television

Not at all ☐ | Several days ☐ | More than half the days ☐ | Nearly every day ☐

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

Not at all ☐ | Several days ☐ | More than half the days ☐ | Nearly every day ☐

9. Thoughts that you would be better off dead, or of hurting yourself in some way

Not at all ☐ | Several days ☐ | More than half the days ☐ | Nearly every day ☐

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

1. Feeling nervous, anxious or on edge

Not at all	Several days	More than half the days	Nearly every day
☐	☐	☐	☐

2. Not being able to stop or control worrying

Not at all	Several days	More than half the days	Nearly every day
☐	☐	☐	☐

3. Worrying too much about different things

Not at all	Several days	More than half the days	Nearly every day
☐	☐	☐	☐

4. Trouble relaxing

Not at all	Several days	More than half the days	Nearly every day
☐	☐	☐	☐

5. Being too restless that it is hard to sit still

Not at all	Several days	More than half the days	Nearly every day
☐	☐	☐	☐

6. Becoming easily annoyed or irritable

Not at all	Several days	More than half the days	Nearly every day
☐	☐	☐	☐

7. Feeling afraid as if something awful might happen

Not at all	Several days	More than half the days	Nearly every day
☐	☐	☐	☐

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SECTION 2

This section is about any physical health problems you may be experiencing.
Please cross one box for each health problem.

During the **past 4 weeks**, how much have you been bothered by any of the following problems?

1. Stomach pains

Not bothered at all ☐ Bothered a little ☐ Bothered a lot ☐

2. Back pain

Not bothered at all ☐ Bothered a little ☐ Bothered a lot ☐

3. Pain in your arms, legs, or joints (e.g. knees, hips)

Not bothered at all ☐ Bothered a little ☐ Bothered a lot ☐

4. Headaches

Not bothered at all ☐ Bothered a little ☐ Bothered a lot ☐

5. Chest pain

Not bothered at all ☐ Bothered a little ☐ Bothered a lot ☐

6. Dizziness

Not bothered at all ☐ Bothered a little ☐ Bothered a lot ☐

7. Fainting spells

Not bothered at all ☐ Bothered a little ☐ Bothered a lot ☐

8. Feeling your heart pound or race

Not bothered at all	Bothered a little	Bothered a lot
☐	☐	☐

9. Shortness of breath

Not bothered at all	Bothered a little	Bothered a lot
☐	☐	☐

10. Pain or problems during sexual intercourse

Not bothered at all	Bothered a little	Bothered a lot
☐	☐	☐

11. Constipation, loose bowels, or diarrhoea

Not bothered at all	Bothered a little	Bothered a lot
☐	☐	☐

12. Nausea, gas, or indigestion

Not bothered at all	Bothered a little	Bothered a lot
☐	☐	☐

13. Feeling tired or having low energy

Not bothered at all	Bothered a little	Bothered a lot
☐	☐	☐

14. Trouble sleeping

Not bothered at all	Bothered a little	Bothered a lot
☐	☐	☐

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SECTION 3

This section asks you about how you've been feeling.

Answer each question by placing a cross in the box that best describes your answer.

1a. Over the **past month** have you been bothered by feeling down, depressed or hopeless?

Yes ☐ No ☐

1b. Over the **past month** have you been bothered by having little or no interest or pleasure in doing things?

Yes ☐ No ☐

2a. I tend to bounce back after illness or hardship

Not true at all	Rarely true	Sometimes true	Often true	True nearly all of the time
☐	☐	☐	☐	☐

2b. I am able to adapt to change

Not true at all	Rarely true	Sometimes true	Often true	True nearly all of the time
☐	☐	☐	☐	☐

SECTION 4

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

Answer each question by placing a cross in the box that best describes your answer.

1. In general, would you say your health is:
(please cross one box only)

Excellent	Very Good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. During a typical day does **your health** limit you in **moderate activitie**s, such as moving a table, pushing a vacuum cleaner, bowling or playing golf? If so, how much?
(please cross one box only)

Yes, limited a lot	Yes, limited a little	No, not limited at all
☐	☐	☐

3. During a typical day does **your health** limit you in climbing **several** flights of stairs? If so, how much?
(please cross one box only)

Yes, limited a lot	Yes, limited a little	No, not limited at all
☐	☐	☐

4. During the **past 4 weeks**, how much of the time have you accomplished less than you would like in regular daily activities **as a result of your physical health**?
(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
☐	☐	☐	☐	☐

5. During the **past 4 weeks**, how much of the time have you been limited in performing any kind of work or other regular daily activities **as a result of your physical health**?
(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
☐	☐	☐	☐	☐

6. During the **past 4 weeks**, how much of the time have you accomplished less than you would have liked in your work or any other regular daily activities **as a result of any emotional problems** (such as feeling depressed or 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
☐	☐	☐	☐	☐

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7. During the **past 4 weeks**, how much of the time have you done work or other activities less carefully than usual **as a result of any emotional problems** (such as feeling depressed or 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 weeks**, how much did **pain** interfere with your normal work (both outside the home and housework)?
(please cross one box only)

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

9. This question is about how you feel and how things have been with you during the **past 4 weeks**. Please give the one answer that comes closest to the way you have been feeling. How much during the **past 4 weeks** have you felt calm and peaceful ?
(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
☐	☐	☐	☐	☐

10. This question is about how you feel and how things have been with you during the **past 4 weeks**. Please give the one answer that comes closest to the way you have been feeling. How much during the **past 4 weeks** did you have a lot of energy ?
(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
☐	☐	☐	☐	☐

11. This question is about how you feel and how things have been with you during the **past 4 weeks**. Please give the one answer that comes closest to the way you have been feeling. How much during the **past 4 weeks** have you felt downhearted and depressed?
(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
☐	☐	☐	☐	☐

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

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SECTION 5

This section also asks about your health in general.

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

Mobility

I have no problems in walking about ☐

I have some problems in walking about ☐

I am confined to bed ☐

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 ☐

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 ☐

Pain/Discomfort

I have no pain or discomfort ☐

I have moderate pain or discomfort ☐

I have extreme pain or discomfort ☐

Anxiety/Depression

I am not anxious or depressed ☐

I am moderately anxious or depressed ☐

I am extremely anxious or depressed ☐

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SECTION 6

This section is about any medication you have been prescribed to improve your mental well-being.

Are you **currently** prescribed any of the medicines listed below?

Yes ☐ No ☐ Don’t know ☐

If 'Yes', please cross all that apply.

Dosulepin ☐	Sertraline ☐	Venlafaxine ☐
Lofepramine ☐	Fluoxetine ☐	Duloxetine ☐
Citalopram ☐	Paroxetine ☐	Trazodone ☐
Mirtazapine ☐	Other ☐ *please list any other medications below*	

1. ______ 2. ______

3. ______ 4. ______

5. ______ 6. ______

7. ______ 8. ______

9. ______ 10. ______

If you **are** prescribed one of these medicines but have stopped taking it for any reason please place a cross in this box. ☐

SECTION 7

This section asks about any health care you have received as a patient **for any reason** (please do not include any visits to your GP practice).

Answer each question by placing a cross in the box that best describes your answer.

Attending hospital

1a. During the **last 6 months** have you stayed overnight in hospital?

Yes ☐ No ☐ (go to 2a) Don't know ☐

1b. If 'Yes', On how many separate occasions did you stay overnight in hospital? ☐☐

Please provide some details for each occasion you stayed in hospital (e.g. hip replacement, fall).

(if you have stayed more than 2 occasions, we will contact you for further details)

1c. **First hospital visit**

1d. After your hospital visit were you:

- Transferred to community hospital (e.g. for rehabilitation) ☐
- Discharged back to your home ☐
- Other (please state) ☐

1e. **Second hospital visit**

1f. After your hospital visit were you:

- Transferred to community hospital (e.g. for rehabilitation) ☐
- Discharged back to your home ☐
- Other (please state) ☐

Other visits to hospital

2a. Have you attended Accident and Emergency in the **last 6 months**?

Yes ☐ No ☐ (go to 3a) Don't know ☐

2b. If 'Yes', how many times have you attended Accident and Emergency in the **last 6 months**? ☐☐

3a. Have you attended Hospital Outpatients in the **last 6 months**?

Yes ☐ No ☐ (go to 4a) Don't know ☐

3b. If 'Yes', how many times have you attended Hospital Outpatients in the **last 6 months**? ☐☐

4a. Have you attended hospital as a day case/procedure patient in the **last 6 months**?

Yes ☐ No ☐ (go to 5a) Don't know ☐

4b. If 'Yes', how many times have you attended hospital as a day case/procedure in the **last 6 months?** ☐☐

NHS transport services

5a. Have you used a '999' emergency ambulance in the **last 6 months**?

Yes ☐ No ☐ (go to 6a) Don't know ☐

5b. If 'Yes', how many times have you used a '999' emergency ambulance in the **last 6 months**? ☐☐

6a. Have you used the Patient Transport Service in the **last 6 months**?

Yes ☐ No ☐ (go to 7a) Don't know ☐

6b. If 'Yes', how many times have you used the Patient Transport Service in the **last 6 months**? ☐☐

Other NHS services

7a. Have you gone to an NHS Walk-in Centre in the **last 6 months**?

Yes ☐ No ☐ (go to 8a) Don't know ☐

7b. If 'Yes', how many times have you been to an NHS Walk-in Centre in the **last 6 months**? ☐☐

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8a. Have you called NHS Direct (the NHS telephone helpline) in the **last 6 months**?

Yes ☐ No ☐ (go to 9a) Don't know ☐

8b. If 'Yes', how many times have you called NHS Direct (the NHS telephone helpline) in the **last 6 months**? ☐☐

Support services

9a. Do you receive any home help?

Yes ☐ No ☐ (go to 10a) Don't know ☐

9b. Thinking about the **last 6 months**, of these how many months did you have home help? (please count any month where you have had a visit)

0 months ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months ☐

9c. Thinking about the **last 6 months**, typically, how many times a week did home help visit?

0 days ☐ 1 day ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days ☐

10a. Does a care worker visit you at home?

Yes ☐ No ☐ (go to 11a) Don't know ☐

10b. Thinking about the **last 6 months**, of these how many months did a care worker visit you at home? (please count any month where you have had a visit)

0 months ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months ☐

10c. Thinking about the **last 6 months**, typically, how many times a week did a care worker visit?

0 days ☐ 1 day ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days ☐

11a. Do you use meals on wheels?

Yes	No	Don't know
☐	☐ (go to 12a)	☐

11b. Thinking about the **last 6 months**, of these how many months did you use meals on wheels? (please count any month where you have had a visit)

0 months	1 month	2 months	3 months	4 months	5 months	6 months
☐	☐	☐	☐	☐	☐	☐

11c. Thinking about the **last 6 months**, typically, how many times a week did you use meals on wheels?

0 days	1 day	2 days	3 days	4 days	5 days	6 days	7 days
☐	☐	☐	☐	☐	☐	☐	☐

12a. Do you go to any community centres?

Yes	No	Don't know
☐	☐	☐

12b. Thinking about the **last 6 months**, typically, how many times a week do you go to a community centre?

0	1-2	2-3	3-4	4+
☐	☐	☐	☐	☐

12c. Which community centres do you attend?

SECTION 8

This section is about your views on how well you understood the different aspects of the CASPER Study before you signed the consent form.

Each of the 10 questions below relates to a different aspect. Answer each question by circling the number that best describes your answer

For example:

If you didn't understand them at all, please circle 1.
If you understood it very well, please circle 5.
If you understand it somewhat, please circle a number between 1 and 5.

		I didn't understand this at all				I understood this very well
1.	What the researchers are trying to find out in the study	1	2	3	4	5
2.	How long you will be in the study	1	2	3	4	5
3.	The treatments and procedures you will undergo	1	2	3	4	5
4.	The possible risks and discomforts of participating in the study	1	2	3	4	5
5.	The possible benefits to you of participating in the study	1	2	3	4	5
6.	How your participation in this study may benefit future patients	1	2	3	4	5
7.	The effects of the study on the confidentiality of your medical records	1	2	3	4	5
8.	Whom you should contact if you have questions or concerns about the study	1	2	3	4	5
9.	The fact that participation in the study is voluntary	1	2	3	4	5
10.	Overall, how well did you understand the study when you signed the consent form?	1	2	3	4	5

SECTION 9

This final section is a list of important life events. For each life event please circle 'Yes' if you have experienced that life event **over the last year** and 'No' if you have not. For those that you have experienced, please also indicate the date that the event occurred with as much accuracy as you can.

Life event	Y / N		Timing Month / Year
You yourself suffered a serious illness, injury or an assault	Yes	No	☐☐ / ☐☐
A serious illness, injury or assault happened to a close relative	Yes	No	☐☐ / ☐☐
Your child, spouse or parent died	Yes	No	☐☐ / ☐☐
A close family friend or another relative (niece, cousin, grandchild) died	Yes	No	☐☐ / ☐☐
You had a separation due to marital difficulties	Yes	No	☐☐ / ☐☐
You broke off a steady relationship	Yes	No	☐☐ / ☐☐
You had a serious problem with a close friend, neighbour or relative	Yes	No	☐☐ / ☐☐
You became unemployed or you were seeking work unsuccessfully for more than one month	Yes	No	☐☐ / ☐☐
You were sacked from your job	Yes	No	☐☐ / ☐☐
You had a major financial crisis	Yes	No	☐☐ / ☐☐
You had problems with the police and a court appearance	Yes	No	☐☐ / ☐☐
Something you valued was lost or stolen	Yes	No	☐☐ / ☐☐

If you have any general comments about the study, or this questionnaire, please write them below.

Thank you for completing this questionnaire.
Please return it in the pre-paid envelope provided.