

CONFIDENTIAL



Baseline Questionnaire

Participant's trial ID number:

 -

Date questionnaire sent:

 / / 2 0
Day Month Year

Funded by:



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Organised by:



THE UNIVERSITY of York


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1836551920

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?

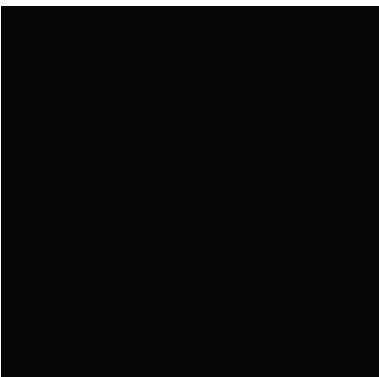
7	5
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 years

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:



Please enter the date you are completing this questionnaire:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text" value="2"/>	<input type="text" value="0"/>	<input type="text"/>	<input type="text"/>
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.

- Little interest or pleasure in doing things
Not at all Several days More than half the days Nearly every day
- Feeling down, depressed, or hopeless
Not at all Several days More than half the days Nearly every day
- Trouble falling or staying asleep, or sleeping too much
Not at all Several days More than half the days Nearly every day
- Feeling tired or having little energy
Not at all Several days More than half the days Nearly every day
- Poor appetite or overeating
Not at all Several days More than half the days Nearly every day
- 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
- 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
- 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
- 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

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

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

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 activities**, 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

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

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

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**?

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
 (go to 12a)

Don't know

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	<input type="text"/>	<input type="text"/>
A serious illness, injury or assault happened to a close relative	Yes		No	<input type="text"/>	<input type="text"/>
Your child, spouse or parent died	Yes		No	<input type="text"/>	<input type="text"/>
A close family friend or another relative (niece, cousin, grandchild) died	Yes		No	<input type="text"/>	<input type="text"/>
You had a separation due to marital difficulties	Yes		No	<input type="text"/>	<input type="text"/>
You broke off a steady relationship	Yes		No	<input type="text"/>	<input type="text"/>
You had a serious problem with a close friend, neighbour or relative	Yes		No	<input type="text"/>	<input type="text"/>
You became unemployed or you were seeking work unsuccessfully for more than one month	Yes		No	<input type="text"/>	<input type="text"/>
You were sacked from your job	Yes		No	<input type="text"/>	<input type="text"/>
You had a major financial crisis	Yes		No	<input type="text"/>	<input type="text"/>
You had problems with the police and a court appearance	Yes		No	<input type="text"/>	<input type="text"/>
Something you valued was lost or stolen	Yes		No	<input type="text"/>	<input type="text"/>

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.**