

BASELINE QUESTIONNAIRE TABLE OF CONTENTS

In order of administration
 IA = interviewer administered
 SA = self administered

| | Scale | Name of | # of items |
|-----|-------|---|------------|
| 1) | IA | Baseline Characteristics -- | |
| 2) | SA | Yesavage Geriatric Depression Scale 30 (administered only if depression is failed on screener) | |
| 3) | IA | Folstein Mini Mental Status Exam (MMSE) 8* (administered to make sure participant is suitable) (Copy in file cabinet only) | |
| 4) | SA | Health Status Questionnaire (MOS SF-36) 36 | |
| 5) | SA | NHIS Disability Days 2 | |
| 6) | SA | Patient Satisfaction Questionnaire 20 | |
| 7) | IA | Perceived Efficacy in Patient-Physician Interactions (PEPPI)10 | |
| 8) | IA | Quality of Well-Being (QWB) 47 | |
| 9) | IA | Illness Self Mastery 5 | |
| 10) | IA | NIA Battery Administration Protocol 3* | |
| 11) | IA | Physical Performance Test 7* | |

* Tasks, rather than questions, to be completed

Assemble packets as follows:

- 1) Baseline Characteristics + Yesavage + Folstein
- 2) MOS + NHIS + Patient Satisfaction
- 3) PEPPI + QWB + Illness Self Mastery + NIA + PPT

Name: _____
ID# _____

Date: ____/____/____

SA

HEALTH STATUS QUESTIONNAIRE (SF-36)

The following questions are about activities you might do during a typical day. Does your health **now** limit you in these activities, if so, how much?

1. Does your health now limit you in vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports?

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

2. Does your health now limit you in moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?

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

3. Does your health now limit you in lifting or carrying groceries?

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

4. Does your health now limit you in climbing several flights of stairs?

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

5. Does your health now limit you in climbing one flight of stairs?

Yes, limited a lot

Yes, limited a little

No, not limited at all

6. Does your health now limit you in bending, kneeling, or stooping?

Yes, limited a lot

Yes, limited a little

No, not limited at all

7. Does your health now limit you in walking more than a mile?

Yes, limited a lot

Yes, limited a little

No, not limited at all

8. Does your health now limit you in walking several blocks?

Yes, limited a lot

Yes, limited a little

No, not limited at all

9. Does your health now limit you in walking one block?

Yes, limited a lot

Yes, limited a little

No, not limited at all

10. Does your health now limit you in bathing or dressing yourself?

Yes, limited a lot

Yes, limited a little

No, not limited at all

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

11. During the past 4 weeks, have you cut down the amount of time you spent on work or other activities as a result of your physical health?

Yes

No

12. During the past 4 weeks, have you accomplished less than you would like as a result of your physical health?

Yes

No

13. During the past 4 weeks, were you limited in the kind of work or other activities as a result of your physical health?

Yes

No

14. During the past 4 weeks, did you have difficulty performing your work or other activities (for example, it took extra effort) as a result of your physical health?

Yes

No

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

15. During the past 4 weeks, have you cut down the amount of time you spent on work or other activities as a result of emotional problems?

Yes

No

16. During the past 4 weeks, have you accomplished less than you would like as a result of emotional problems?

Yes

No

17. During the past 4 weeks did you do work or other activities less carefully than usual as a result of emotional problems?

___ Yes

___ No

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

18. During the past 4 weeks, how much of the time did you feel full of pep?

___ All of the time

___ Most of the time

___ A good bit of the time

___ Some of the time

___ A little of the time

___ None of the time

19. During the past 4 weeks, how much of the time have you been a very nervous person?

___ All of the time

___ Most of the time

___ A good bit of the time

___ Some of the time

___ A little of the time

___ None of the time

20. During the past 4 weeks, how much of the time have you felt so down in the dumps that nothing could cheer you up?

___ All of the time

___ Most of the time

___ A good bit of the time

___ Some of the time

___ A little of the time

___ None of the time

21. During the past 4 weeks, how much of the time have you felt calm and peaceful?
- All of the time
 - Most of the time
 - A good bit of the time
 - Some of the time
 - A little of the time
 - None of the time
22. During the past 4 weeks, how much of the time did you have a lot of energy?
- All of the time
 - Most of the time
 - A good bit of the time
 - Some of the time
 - A little of the time
 - None of the time
23. During the past 4 weeks, how much of the time have you felt downhearted and blue?
- All of the time
 - Most of the time
 - A good bit of the time
 - Some of the time
 - A little of the time
 - None of the time
24. During the past 4 weeks, how much of the time did you feel worn out?
- All of the time
 - Most of the time
 - A good bit of the time
 - Some of the time
 - A little of the time
 - None of the time

25. During the past 4 weeks, how much of the time have you been a happy person?
- All of the time
 - Most of the time
 - A good bit of the time
 - Some of the time
 - A little of the time
 - None of the time
26. During the past 4 weeks, how much of the time did you feel tired?
- All of the time
 - Most of the time
 - A good bit of the time
 - Some of the time
 - A little of the time
 - None of the time
27. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
- All of the time
 - Most of the time
 - Some of the time
 - A little of the time
 - None of the time
28. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
- Not at all
 - Slightly
 - Moderately
 - Quite a bit
 - Extremely

29. How much bodily pain have you had during the past 4 weeks?

- None
- Very mild
- Mild
- Moderate
- Severe
- Very severe

30. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

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

Please choose the answer that best describes how true or false each of the following statements is for you.

31. I seem to get sick a little easier than other people.

- Definitely true
- Mostly true
- Not sure
- Mostly false
- Definitely false

32. I am as healthy as anybody I know.

- Definitely true
- Mostly true
- Not sure
- Mostly false
- Definitely false

33. I expect my health to get worse

- Definitely true
- Mostly true
- Not sure
- Mostly false
- Definitely false

34. My health is excellent

- Definitely true
- Mostly true
- Not sure
- Mostly false
- Definitely false

35. In general, would you say your health is...

- Excellent
- Very good
- Good
- Fair
- Poor

36. Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same
- Somewhat worse now than one year ago
- Much worse now than one year ago

ID#_____

NHIS DISABILITY DAYS

1. In the past four weeks, did you cut down the things you usually do, such as going to work or working around the house, because of illness or injury?

___ No

___ Yes

If yes, How many days did you cut down on the things you usually do because of illness or injury?
_____ days

2. In the past four weeks, did you ever stay in bed because of an illness or injury?

___ No

___ Yes

If yes, How many days did you stay in bed at least half the day because of illness or injury?
_____days

ID# _____
IA

PATIENT SATISFACTION QUESTIONNAIRE

On the following pages are some things people say about medical care. Please read each one carefully, keeping in mind the medical care you are receiving now. (If you have not received care recently, think about what you would expect if you needed care today.) We are interested in your feelings, good and bad, about the medical care you have received.

How strongly do you AGREE or DISAGREE with each of the following statements?

1. Doctors are good about explaining the reason for medical tests.

___ Strongly disagree
__ Disagree
___ Uncertain
___ Agree
___ Strongly agree

2. The doctors who treat me should give me more respect.

___ Strongly disagree
___ Disagree
___ Uncertain
___ Agree
___ Strongly agree

3. The medical care I have been receiving is just about perfect.

___ Strongly disagree
___ Disagree
___ Uncertain
___ Agree
___ Strongly agree

4. Sometimes doctors use medical terms without explaining what they mean.
- Strongly disagree
 - Disagree
 - Uncertain
 - Agree
 - Strongly agree
5. During my medical visits, I am always allowed to say everything that I think is important.
- Strongly disagree
 - Disagree
 - Uncertain
 - Agree
 - Strongly agree
6. There are things about the medical system I receive my care from that need to be improved.
- Strongly disagree
 - Disagree
 - Uncertain
 - Agree
 - Strongly agree
7. The doctors who treat me have a genuine interest in me as a person.
- Strongly disagree
 - Disagree
 - Uncertain
 - Agree
 - Strongly agree
8. Sometimes doctors make me feel foolish.
- Strongly disagree
 - Disagree
 - Uncertain
 - Agree
 - Strongly agree

9. All things considered, the medical care I receive is excellent.
- Strongly disagree
 - Disagree
 - Uncertain
 - Agree
 - Strongly agree
10. Doctors act too businesslike and impersonal toward me.
- Strongly disagree
 - Disagree
 - Uncertain
 - Agree
 - Strongly agree
11. There are some things about the medical care I receive that could be better.
- Strongly disagree
 - Disagree
 - Uncertain
 - Agree
 - Strongly agree
12. My doctors treat me in a very friendly and courteous manner.
- Strongly disagree
 - Disagree
 - Uncertain
 - Agree
 - Strongly agree
13. Those who provide my medical care sometimes hurry too much when they treat me.
- Strongly disagree
 - Disagree
 - Uncertain
 - Agree
 - Strongly agree

14. I am very satisfied with the medical care I receive.

- Strongly disagree
- Disagree
- Uncertain
- Agree
- Strongly agree

15. Doctors sometimes ignore what I tell them.

- Strongly disagree
- Disagree
- Uncertain
- Agree
- Strongly agree

16. Doctors listen carefully to what I have to say.

- Strongly disagree
- Disagree
- Uncertain
- Agree
- Strongly agree

17. When I am receiving medical care, they should pay more attention to my privacy.

- Strongly disagree
- Disagree
- Uncertain
- Agree
- Strongly agree

18. Doctors usually spend plenty of time with me.

- Strongly disagree
- Disagree
- Uncertain
- Agree
- Strongly agree

19. I am dissatisfied with some things about the medical care I receive.

- Strongly disagree
- Disagree
- Uncertain
- Agree
- Strongly agree

20. Doctors always do their best to keep me from worrying.

- Strongly disagree
- Disagree
- Uncertain
- Agree
- Strongly agree

May be eliminated

ID# _____

GLOBAL SELF MASTERY

How strongly do you agree or disagree with the following statements?

1. I am generally able to take care of a health problem through my own efforts.

Strongly disagree
 Disagree
 Somewhat disagree
 Somewhat agree
 Agree
 Strongly agree

2. If I become sick, I have the power to make myself well again.

Strongly disagree
 Disagree
 Somewhat disagree
 Somewhat agree
 Agree
 Strongly agree

3. I have a lot of confidence in my ability to cure myself once I get sick.

Strongly disagree
 Disagree
 Somewhat disagree
 Somewhat agree
 Agree
 Strongly agree

4. When I have a health problem, I am usually able to cope with it on my own.

Strongly disagree
 Disagree
 Somewhat disagree
 Somewhat agree
 Agree
 Strongly agree

ID# _____

IA

QUALITY OF WELL-BEING:Modified

- B. For each of the following symptoms or problems determine if the patient experienced this problem **yesterday**.

"I'm going to ask you about a few symptoms you may have experienced in the past **day**." (Check all that apply)

"Did you have this symptom or problem **yesterday**?"

1. Loss of consciousness
 Yes
 No
2. Trouble remembering or thinking clearly
 Yes
 No
3. Pain in the stomach
 Yes
 No
4. Pain or other discomfort in the chest
 Yes
 No
5. Groin pain, bleeding, itching or abdominal discharge
 Yes
 No
6. Pain in your joints, like your neck, back, arms or legs
 Yes
 No

If any symptoms or problems were endorsed in this section, skip to Section D.

C. If **none** of the symptoms were experienced in Section B. determine if the patient experienced any of the following problems in the **past** day. Continue down the list until a problem is identified (if any). Once a problem is identified, skip to Section D.

"Did you have this symptom or problem **yesterday**?"

1. Difficulty with bowel movements or any pain or discomfort in the rectal area
 Yes
 No
2. Difficulty urinating
 Yes
 No
3. Upset stomach, vomiting or diarrhea
 Yes
 No
4. General tiredness, weakness, or weight loss
 Yes
 No
5. Cough, wheezing, or shortness of breath
 Yes
 No
6. Spells of feeling upset, depressed or crying
 Yes
 No
7. Headache
 Yes
 No
8. Dizziness, or ringing in ears
 Yes
 No
9. Spells of feeling hot, nervous, or shaky
 Yes
 No
10. Burning or itching rash on large areas of the body
 Yes
 No

11. Trouble talking (e.g. lisp, stuttering, hoarseness, or being unable to speak)
 Yes
 No
12. Any trouble seeing with or without glasses or contact lenses
 Yes
 No
13. Burning itching or pain in one or both eyes
 Yes
 No
14. A problem with being overweight or underweight
 Yes
 No
15. Any very noticeable skin imperfections, many warts or large scars
 Yes
 No
16. Trouble hearing with or without a hearing aid
 Yes
 No
17. A stuffy or runny nose
 Yes
 No
18. A sore throat
 Yes
 No
19. An earache
 Yes
 No
20. A toothache
 Yes
 No
21. Sore lips, tongue, or gums
 Yes
 No
22. A problem with missing or crooked teeth
 Yes
 No

23. Were you supposed to take prescribed medication or follow a prescribed diet for health reasons (This asks if one or both were **prescribed**, not what the patient did.)

Yes

No

24. Wore glasses or contact lenses

Yes

No

25. A problem with breathing smog or unpleasant air

Yes

No

26. Any other symptoms, health complaints, or pains that have not been mentioned?

(Describe: _____)

Yes

No

1. Did you drive or ride in a car yesterday?

Yes

If yes: Did you use help from another person in order to drive a car yesterday? If so, why?

Yes, health related

Yes, not health related

No

No

If no: Were the reasons you did not drive yesterday related in any way to your health?

Yes

No

2. Did you use any public transportation yesterday?

Yes

If yes: Did you use help from another person to use public transportation yesterday? If so, why?

Yes, health related

Yes, not health related

No

No

If no: Were the reasons you did not use public transportation yesterday related in any way to your health?

Yes

No

If no: If you HAD used public transportation yesterday, would you have used help from another person? If so, why?

Yes, health related

Yes, not health related

No

E. PHYSICAL ACTIVITY: your level of physical activity
yesterday

1. Did you spend more than half of yesterday in a wheelchair?

Yes

If yes: Did you move or control the movement of the wheelchair without help most of the time yesterday?

Yes

No. Skip to Section F.

No

2. Did you spend more than half of yesterday in bed? If so, why?

Yes, health related. Skip to Section F.

Yes, not health related. Skip to Section F.

No

4. Did you spend more than half of yesterday in a chair? If so why?

Yes, health related

Yes, not health related

No

5. Did you limp or use a cane, crutch or walker yesterday?

Yes

No

F. DAILY ACTIVITIES:

1. Did you use help from another person with your personal care needs? (such as eating, bathing, dressing, or getting around your home.) If so, why?

Yes, health related
 Yes, not health related
 No

2. Did you use help from another person in handling your routine needs? (such as everyday chores, doing necessary business, shopping, or getting around for other purposes).

Yes, health related
 Yes, not health related
 No

3. Did you do any household activities? (such as working in or around the house or yard, caring for children, cooking, or cleaning)

Yes

If yes: Were you limited in any way in the amount or kind of household activities you did? (such as not doing certain tasks or strenuous work, or taking special rest periods or working only part of the day)

Yes
 No

No

If no: Was the reason you did not do any household activities related in any way to your health?

Yes
 No

If no: If you HAD done household activities, would you have been limited in any way in the amount or kind of work done? (such as not doing certain tasks or strenuous work, or taking special rest periods)

Yes, health related
 Yes, not health related
 No

4. Were you limited in any activities other than household activities, such as hobbies, shopping, recreational, social, or religious activities? If so, why?

Yes, health related

Yes, not health related

No

ID# _____

NIA BATTERY ADMINISTRATION PROTOCOL: long

I. Summary Performance Scale

| | Time | Category Score |
|---------------------------|---------|----------------|
| Standing Balance | xxxxxxx | |
| Timed 8 Foot Walk | | |
| Timed Repeat Chair Stands | | |
| TOTAL SCORE | | |

II. Standing Balance

A. No aids, such as walker or cane, may be used for this task.

B. Start with semi-tandem stand.

1. Do full tandem if subject holds semi-tandem for 10 seconds.
2. Do side by side if subject fails to hold semi-tandem for 10 seconds.

c. Score is determined by highest level successfully completed.

Example 1: Score is 3 if subject holds semi-tandem for 10 seconds and full tandem for 5 seconds.

Example 2: Score is 1 if subjects fails to hold semi-tandem for 10 seconds but holds side by side for 10 seconds.

| Category Score (circle) | a. Side by Side: Feet parallel and touching. Time: _____secs. | b. Semi-Tandem: Heel of one foot to side of big toe of other foot. Time: _____secs. | c. Full Tandem: Heel of one foot touches big toe of other foot. Time: _____secs. |
|----------------------------|---|---|--|
| 0 | Held 0-9 seconds or tried but unable or not attempted. | Held 0-9 seconds or tried but unable or not attempted. Try side by side if appropriate. | |
| 1 | Held 10 seconds. | Held 0-9 seconds or tried by unable or not attempted. | |
| 2 | | Held 10 seconds. | Held 0-2 seconds tried but unable not attempted. |
| 3 | | Held 10 seconds. | Held 3-9 seconds |
| 4 | | Held 10 seconds. | Held 10 seconds. |

III. Timed 8 Foot Walk

A. Use tape measure to mark 8 feet and 25 feet with masking tape. The course must be straight and unobstructed. Allow at least a couple of feet of clearance at either end.

B. Instruct subject to "walk to the first mark at your usual speed, just as if you were walking down the street to go to the store." The subject may use a walking aid, if necessary.

C. Time the 8 foot walk. Repeat the walk a second time unless the subject performs the first walk in less than 4 seconds.

D. Use the best performance for determining the category score.

| Category Score (circle) | First 8 foot walk: Time:_____secs. | Second 8 foot walk: Time:_____ secs. | Walking aid used? If yes, specify. |
|-------------------------|------------------------------------|--------------------------------------|------------------------------------|
| 0 | Unable to complete | Unable to complete | |
| 1 | More than 5.6 secs | More than 5.6 secs. | |
| 2 | 4.1 thru 5.6 secs. | 4.1 thru 5.6 secs. | |
| 3 | 2.0 thru 4.0 secs. | 2.0 thru 4.0 secs. | |
| 4 | Less than 2.0 secs | Less than 2.0 secs. | |

IV. Timed Repeat Chair Stands

A. Place an armless, firm, straight-backed chair against a wall.

B. Have the subject sit in the chair with arms folded across his/her chest then stand up. Arms must remain folded, and no aids may be used. If the subject doesn't keep arms folded or touches the chair note on the form, repeat the instructions and try again.

C. If successful, ask the subject to stand up and sit down five times as quickly as possible. Time from the initial sitting position to the final standing position at the end of the fifth stand.

D. Record the time, and select the appropriate category score.

| Category Score (circle) | 5 Chair Stands Time:_____ secs. |
|-------------------------|---------------------------------|
| 0 | Unable to complete |
| 1 | More than 16.7 secs. |
| 2 | 13.7 thru 16.7 secs. |
| 3 | 11.2 thru 13.6 secs. |
| 4 | Less than 11.2 secs. |
| Repeat? | |

IA

ID# _____

NIA BATTERY ADMINISTRATION PROTOCOL: short

| PERFORMANCE SCALE | Time | Score |
|---------------------------|---------|-------|
| Standing Balance | xxxxxxx | |
| Timed 8 Foot Walk | | |
| Timed Repeat Chair Stands | | |
| TOTAL SCORE | | |

| STANDING BALANCE Score (circle) | a. Side by Side: Time: _____secs. | b. Semi-Tandem: Time: _____secs. | c. Full Tandem: Time: _____secs. |
|---------------------------------------|---|---|--|
| 0 | Held 0-9 secs, tried & unable, not tried. | Held 0-9 secs, tried & unable, not tried. | |
| 1 | Held 10 seconds. | Held 0-9 secs, tried & unable, not tried. | |
| 2 | | Held 10 seconds. | Held 0-2 secs, tried & unable, not tried |
| 3 | | Held 10 seconds. | Held 3-9 seconds. |
| 4 | | Held 10 seconds. | Held 10 seconds. |

| 8FT WALK Score (circle) | First 8 Foot Walk: Time: _____secs. | Second 8 Foot Walk: Time: _____secs. | Walking aid used? If yes, specify. |
|-------------------------------|--|---|---------------------------------------|
| 0 | Unable to complete | Unable to complete | |
| 1 | More than 5.6 secs | More than 5.6 secs. | |
| 2 | 4.1 thru 5.6 secs. | 4.1 thru 5.6 secs. | |
| 3 | 2.0 thru 4.0 secs. | 2.0 thru 4.0 secs. | |
| 4 | Less than 2.0 secs | Less than 2.0 secs. | |

| Score (circle) | 5 CHAIR STANDS Time: _____secs. |
|-------------------|------------------------------------|
| 0 | Unable to complete |
| 1 | More than 16.7 secs. |
| 2 | 13.7 thru 16.7 secs. |
| 3 | 11.2 thru 13.6 secs. |
| 4 | Less than 11.2 secs. |
| Repeat? | |

Health Status Questionnaire (SF-36) responses for Q's 1-10

Yes, limited a lot

Yes, limited a little

No, not limited at all

Health Status Questionnaire (SF-36) responses for Q's 18-27

All of the time

Most of the time

A good bit of the time

Some of the time

A little of the time

None of the time

Health Status Questionnaire (SF-36) responses for Q's 28,30

Not at all

Slightly

Moderately

Quite a bit

Extremely

Health Status Questionnaire (SF-36) responses for Q 29

None

Very mild

Mild

Moderate

Severe

Very severe

Health Status Questionnaire (SF-36) responses for Q's 31-34

Definitely true

Mostly true

Not sure

Mostly false

Definitely false

Health Status Questionnaire (SF-36) responses for Q 35

Excellent

Very good

Good

Fair

Poor

Health Status Questionnaire (SF-36) responses for Q's 31-34

Much better than one year ago

Somewhat better now than one year ago

About the same

Somewhat worse than one year ago

Much worse now than one year ago

Patient Satisfaction Questionnaire reponses for all Q's

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

Quality of Well-Being responses for:

Physical Activity Q's 3, 4

Social Activity Q's 1, 2, 3 subsection, 4

Yes, health related

Yes, not health related

No

Perceived Efficacy in Physician-Patient Interactions (PEPPI)
responses for all Q's

C O N F I D E N C E L E V E L

1.....2.....3.....4.....5

Not at all
Confident

Very
Confident