Health Questionnaire

University of Iowa
College of Public Health
Please INSERT YOUR PARTICIPATION IDENTIFICATION NUMBER:

Please identify who is answering the questionnaire:

Are you the Primary person who sustained the injury, a Family Member (Significant Other) to the person with brain injury, or other? Please choose only one answer:

☐ Person with injury  ☐ Family member/SO  ☐ Other

SECTION ONE: EURO-QOL

By placing a tick in one box in each group below, please indicate which statements best describe 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  □
To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.
SECTION TWO: Clinical Assessment

Now you will be asked questions regarding your health (Please ONLY choose one that applies)

1. During the last SEVEN DAYS, did you feel like hurting yourself?
   - Yes
   - No

2. How much of the time do you get needed social and emotional support?
   - All of the time
   - Most of the time
   - Some of the time
   - A little of the time
   - None of the time

3. How satisfied are you with your life?
   - Very Satisfied
   - Satisfied
   - Neutral
   - Dissatisfied
   - Very Dissatisfied

4. Compared to the early times of your injury, how much improvement do you see?
   - Great improvement
   - Big improvement
   - Little Improvement
   - No Improvement at All

5. During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?
   - Yes
   - No

6. Considering all types of alcoholic beverages, how many times during the past 30 days did you have [5 for men, 4 for women] or more drinks on an occasion?
   - Enter the number
   - Never

7. Do you now smoke cigarettes every day, some days, or not at all?
   - Every day
   - Some days
   - Not at all
SECTION THREE: DISABILITY STATUS, USE OF ASSISTIVE DEVICES, and REHAB SERVICES QUESTIONS

In this section, we are asking about the extent of your limitations and whether you are receiving rehabilitation services. Rehabilitation programs are doctor-supervised programs designed to assist individuals with their physical or mental condition. The therapists who work in these programs treat a variety of conditions including physical conditions, occupational limitations and narcotic abuse. You may have participated in rehabilitation either by going to inpatient sessions for a certain amount of time or visiting the facility on a daily basis for visits.

1. Since your injury, are you limited in any way in any activities because of physical, mental, or emotional problems?
   - Yes
   - No

2. Because of your injury, do you need any special equipment, such as a cane, a wheelchair, a special bed, or a special telephone to function as usual?
   - Yes
   - No

3. Please check any of the listed Rehabilitation services that you have used since your injury:
   - Physical Therapy (PT)  ; Number of Days: 
   - Cognitive Therapy  ; Number of Days: 
   - Occupational Therapy (OT)  ; Number of Days: 
   - Behavioral and Psychological Services  ; Number of Days: 
   - Ophthalmological/Eye Treatments  ; Number of Days: 
   - Hearing Treatments  ; Number of Days: 
   - Alcohol/Drug Rehabilitation  ; Number of Days: 
   - Speech Therapy  ; Number of Days: 
   - Other , Please Specify:  ; Number of Days:
SECTION FOUR: DEMOGRAPHICS AND SOCIAL ECONOMICS

1. What is your date of birth?
   Enter (MM/DD/YYYY)

2. What is your Gender?
   - Male
   - Female
   - Other
   Please specify

4. What type of insurance do you carry now? Check all that apply
   - Private Insurance from employment
   - Private insurance from Spouse or Significant Other
   - Medicaid
   - Workers Compensation
   - Other type of insurance; Please specify:

3. Were you working (Hired) in a regular job when the injury occurred?
   - Yes as a regular employee
   - Yes as a private contractor
   - No, I was working for myself

4. What specific type of job activities were you doing when the injury occurred? Check all that apply
   - Management Occupation
   - Business and Financial Occupation
   - Computer and Mathematical Occupation
   - Architecture and Engineering Occupation
   - Social Science Occupation
   - Community and Social Service Occupation
   - Legal Occupation
   - Education, Training and Library Occupation
5. Did you return to the same job?
   - [ ] Yes in the same position
   - [ ] Yes but in a different position with limited demands
   - [ ] No

6. When did you return to work
   Date of Return to work [ ] (Month/Day/Year)

7. Are you working now?
   - [ ] Yes, Full Time
   - [ ] Yes, Part Time
   - [ ] No, retired
   - [ ] No, unemployed
8. Are receiving disability payment from Worker's compensation?

- Yes
- No

  5/a: If Yes choose the appropriate payment:

- Temporary Total Disability
- Temporary Partial Disability
- Healing Period
- Permanent Partial Disability
- Permanent Total Disability

9. What is your MONTHLY HOUSEHOLD INCOME, from all sources:

Enter the amount

******************************************************************************/End of the questionnaire******************************************************************************/

Thank you so much for taking the time to answer the questionnaire. Please insert in the enclosed and prepaid envelope and mail it to the department. For more information, please contact Mr. Ousmane Diallo
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