

## **Bridges to Weight Management Participant Commitment (For those desiring Bariatric Surgery)**

In an effort to be clear and consistent about program expectations and requirements for those individuals wanting bariatric surgery, the Bridges to Weight Management (BTWM) team has developed the following requirements:

1. Complete an initial assessment and a minimum of two follow-up visits (total of three) with a BTWM behavioral care therapist. Goal of these visits will be to prepare the individual for doing the Physician's Managed Plan (PMP). Preparation will include starting a food log and activity log, making an initial appointment with a BTWM dietitian and personal trainer.
2. Once the above criteria are met, the individual will be referred to the PMP.  
Additional requirements for successful requirements are:
  - Participation in the program for a minimum of 6 months or up to 1 year
  - Be compliant with the M.D.'s recommendations
  - Losing 10% of one's body weight
3. Attend and participate in a minimum of 10 individual behavioral care sessions or "Whatever It Takes" support group meetings, attend 10 out of 13 classes.
4. Have a consultation with a BTWM dietitian and/or complete Nutrition 101, attend 5 out of 6 classes.
5. Have a consultation with a BTWM personal trainer, monthly follow-up appointments and keep an exercise journal to verify activity.
6. Participate in Personal Wellness Coaching (PWC) with a minimum of one contact/month.

I agree to follow the expectations and requirements as outlined on this document.

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Participant

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Date

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Behavioral Care Therapist

# Bridges to Weight Management 2009

## No Show / Short notice cancellation policy for Ancillary programs\*

The Bridges to Weight Management (BTWM) program's policy on missed appointments shall include: 1) No shows, 2) Cancellations with notice (>24 hours), 3) Cancellations-late notice (<24 hours). The purpose of this policy is to clarify for participants and practitioners the policy on no show/cancellations. The policy is not intended to be punitive but rather to value the time and resources of the practitioners and participants.

- 1) **No Show.** The practitioner will record the "no show" in the electronic medical record (EMR). The practitioner will call or email the participant regarding the missed appointment and attempt to reschedule. Additionally the practitioner will inform the participant of this policy and the ramifications of additional "no show" appointments.
- 2) **Cancellations with >24 hour notice.** The practitioner record the cancellation in the EMR and will email or call the participant providing them with an invitation to reschedule following a cancellation with >24 hours notice. After a second occurrence, the owner of the program can either call the client or email the client acknowledging the 2<sup>nd</sup> occurrence. A waiting period for rescheduling may be put in place by the program owner. The owner of the program will decide to make exceptions to the policy on an individual basis.
- 3) **Cancellations with <24 hour notice.** The practitioner will record the cancellation in the EMR and will email or call the participant providing them with an invitation to reschedule following a cancellation with <24 hours notice, following the first occurrence. After the second occurrence, the practitioner can either call client or email the client acknowledging the 2<sup>nd</sup> occurrence. A waiting period for rescheduling may be put in place by the program owner. The practitioner can utilize their discretion in rescheduling based on the reason for the short notice cancellation.
- 4) **Fee.** If a participant has a combination of 3 noshows and/or cancellations <24 hours notice, a fee of \$25.00 must be paid to the Health Promotion department to be reinstated into the program. Further no shows and/or cancellations <24hours will result in dismissal from the program.

\*Ancillary programs – Nutrition 101, Cooking Classes, How To Eat, Grocery Tours, One-on-One Nutrition Counseling, Personal Training and One-on-One Behavioral Counseling

# EMPLOYEE ASSISTANCE PROGRAM

## PERMISSION FOR COUNSELING and NOTICE OF PRIVACY PRACTICES

**Permission for Counseling** I hereby grant permission to the EAP designated counselor to provide such care as may be necessary for me and/or the client named below. I have been given an opportunity to discuss my or the client's conditions with the appropriate personnel.

I understand that my legal right to confidentiality will be maintained except at times when the EAP designated counselor is required *by law* to make disclosures in cases of: 1) child/elder abuse or neglect, 2) homicide or intent to harm someone, 3) or suicidal intent. In those cases, I understand that the counselor will have to notify the appropriate agency personnel and legal authorities in accordance with applicable local, state and federal laws. I also understand that, if I have been referred for EAP services by my employer, the EAP designated counselor may be required to disclose certain limited information, such as my attendance at appointments, to my employer in accordance with my employer's requirements. I understand that this information will *not* be provided to my employer unless I have signed an Authorization for Release of Information form.

**Notice of Privacy Practices** I acknowledge that I have received a copy of the Community Hospitals of Indiana, Inc. and The Indiana Heart Hospital Notice of Privacy Practices Notice of Privacy Practices that describes how medical information about me may be used and disclosed and how I can get access to this information.

**Permission to Transmit Records** I give permission to have my clinical records transmitted by fax to the Hillsdale Office where EAP's central records are kept.

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**Signature**

(Client/Other Legally Responsible Person)

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**Printed Name**

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**Date**

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**Witness**

## EATING ATTITUDE TEST (EAT-26)

Name \_\_\_\_\_

Date \_\_\_\_\_

Always	Usually	Often	Sometimes	Rarely	Never	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Am terrified about being overweight.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Avoid eating when I am hungry.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Find myself preoccupied with food.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Have gone on eating binges where I feel I may not be able to stop.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Cut my food into small pieces.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Aware of the calorie content of foods that I eat.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Particularly avoid foods with high carbohydrate content (e.g. bread, rice, potatoes, etc.).
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Feel that others would prefer if I ate more.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Vomit after I have eaten.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Feel extremely guilty after eating.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Am preoccupied with a desire to be thinner.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Think about burning up calories when I exercise.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Other people think that I am too thin.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Am preoccupied with the thought of having fat on my body.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Take longer than others to eat my meals.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Avoid foods with sugar in them.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Eat diet foods.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Feel that food controls my life.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Display self-control around food.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Feel that others pressure me to eat.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Give too much time and thought to food.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Feel uncomfortable after eating sweets.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Engage in dieting behavior.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Like my stomach to be empty.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Enjoy trying rich new foods.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Have the impulse to vomit after meals.

## ecSatter Inventory

**Below are 16 statements about your eating. Think about each one, then check the box that shows how often you think, do or feel that way.**

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Age \_\_\_\_\_

A = Always   O = Often   S = Sometimes   R = Rarely   N = Never

- |                                                                                    | A                        | O                        | S                        | R                        | N                        |
|------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. I am relaxed about eating.                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I am comfortable about eating enough.                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I enjoy food and eating.                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I am comfortable with my enjoyment of food and eating.                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I feel it is okay to eat food that I like.                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. I experiment with new food and learn to like it.                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. If the situation demands, I can “make do” by eating food I don’t much care for. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. I eat a wide variety of foods.                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. I assume I will get enough to eat.                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. I eat as much as I am hungry for.                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. I eat until I feel satisfied.                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. I tune in to food and pay attention to myself when I eat.                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. I make time to eat.                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. I have regular meals.                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. I think about nutrition when I choose what to eat.                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. I generally plan for feeding myself. I don’t just grab food when I get hungry. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



# Community Health Network

## Employee Assistance Program – Assessment Survey

Welcome to your Community Hospitals' *Employee Assistance Program*. We offer a wide variety of services to promote your overall well-being and healing. To make the best use of your time with the counselor, please take a few minutes to complete this packet of information. We have listed most of the areas that we help people with, however some of these situations may not apply to you. *Thank you again for taking the time to complete this assessment and your answers will remain confidential.*

Name \_\_\_\_\_

Date \_\_\_\_\_

What do you hope to accomplish by coming to EAP? \_\_\_\_\_

What steps have you taken to solve your problem since you made this appointment? \_\_\_\_\_

Do you have someone in your life who understands and supports you?  Yes  No

Are you currently experiencing any of the following problems at work or school?

(check all that apply):

- Overworked (please specify) \_\_\_\_\_
- Conflict with co-worker(s) or peer(s)
- Making mistakes
- Absent from work or school more than usual
- Reprimand or disciplinary action
- Difficulty concentrating
- Feeling that things are not fair
- Poor performance appraisal or bad grades
- Conflict with boss or teacher
- Personal issues that affect work or school
- Family problems that affect work or school
- Getting angry frequently, "short fuse"
- Other (please specify) \_\_\_\_\_

Current Employment Experience (please answer **ONLY** if you are currently working) Please circle your overall performance at work in the past 4 weeks using below scale. Use #1 for the least focused and #10 as the most focused you have ever been in your work.

Least focused    1   2   3   4   5   6   7   8   9   10    Most focused

If you are experiencing any of the following please check *all* that apply:

### Mood/Feelings

- Feeling I am too different
- Having feelings of extreme loneliness
- Concerns about being overweight/underweight
- Fears that make me avoid important activities
- Lack self-confidence

### Family Problems

- Death in my family
- Having marital problems
- Parenting questions
- Feeling afraid of a loved one
- Being slapped, hit, kicked, or pushed by someone
- Having an unhappy home life

### Thoughts

- Difficulty concentrating or making decisions
- Bothered by thoughts running through my head
- Confused as to what I really want

Over →

**Behaviors (check all that apply):**

- Change in appetite with significant weight change
- Trouble falling asleep, trouble staying asleep or early awakening
- Fatigue or loss of energy
- Behavior I can't control

- Lying too much
- Too shy
- Self-harming behaviors
- Procrastinator
- Being a perfectionist
- Speaking or acting without thinking

**Other Experiences (check all that apply):**

- Sometimes feeling things are not real
- Having a permanent illness or physical problem
- History of legal problems or arrests
- Having religious problems or concerns

- Having problems with a significant relationship
- Disturbing sexual experience
- Having financial problems
- Other (please specify) \_\_\_\_\_

**Are any of the following relevant to your past? (check all that apply):**

- Family history of mental illness
- Significant family background problem
- Sexual abuse
- Physical abuse/domestic violence
- Other losses
- Lack of support

- Eating disorder
- Chronic pain
- On-going grief
- Attention deficit disorder
- Past counseling experience
- Other (please specify) \_\_\_\_\_

**Medical Problems**

Please list any significant current or past medical problems \_\_\_\_\_

What was the date of your last physical? \_\_\_\_\_

**Please indicate the current medications and amounts that you are using:**

Over-the-counter medications (be specific)	Dosage (amount)	Frequency
_____	_____	_____
_____	_____	_____

Prescription medications (be specific)	Dosage (amount)	Frequency
_____	_____	_____
_____	_____	_____

Alcohol/Drugs	Dosage (amount)	Frequency
<input type="checkbox"/> Alcohol	_____	_____
<input type="checkbox"/> Caffeine	_____	_____
<input type="checkbox"/> Marijuana	_____	_____
<input type="checkbox"/> Nicotine	_____	_____
<input type="checkbox"/> Other substances (_____)	_____	_____

**Drug and Alcohol Information (check all that apply):**

- I am tempted to cope with stress by using alcohol or drugs
- I sometimes have used alcohol or drugs to calm my nerves
- It takes more for me to feel intoxicated
- I have used more alcohol or drugs than I intended
- The day after using drugs or alcohol I have had physical reactions like a hangover or "shakes"
- When a friend or relative expressed concern about my use I felt annoyed
- I am a recovering alcoholic or drug addict
- My family has a history of problems with drug and alcohol use

- I have felt guilty about my drinking or drug use
- I have used alcohol or drugs despite knowing the legal, social, health, or work consequences
- I have tried to cut down or cut back on my alcohol or drug use
- The above experiences have happened to me within the last year
- Other (please specify \_\_\_\_\_)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Brief Mood Survey\*

Instructions. Use checks (✓) to indicate how depressed, anxious or angry you've been feeling over the past week, including today. Please answer all the items.

	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
<b>Depression</b>					
1. Sad or down in the dumps					
2. Discouraged or hopeless					
3. Low self-esteem					
4. Worthless or inadequate					
5. Loss of pleasure or satisfaction in life					
Total Items 1 to 5 →					

### Suicidal Urges

1. Do you have any suicidal thoughts?					
2. Would you like to end your life?					
Total Items 1 to 2 →					

### Anxiety

1. Anxious					
2. Frightened					
3. Worrying about things					
4. Tense or on edge					
5. Nervous					
Total Items 1 to 5 →					

### Anger

1. Frustrated					
2. Annoyed					
3. Resentful					
4. Angry					
5. Irritated					
Total Items 1 to 5 →					

## Relationship Satisfaction\*

Instructions. Use checks (✓) to show how satisfied or dissatisfied you feel in your closest personal relationship.

Please answer all 5 items.

	Dissatisfied			Satisfied			
	0—Very	1—Moderately	2—Somewhat	3—Neutral	4—Somewhat	5—Moderately	6—Very
1. Communication and openness							
2. Resolving conflicts and arguments							
3. Degree of affection and caring							
4. Intimacy and closeness							
5. Overall satisfaction							
Total Items 1 to 5 →							

## Scoring Keys: Brief Tests

Score	Severity of Depression, Anxiety, Panic or Anger
0 - 1	Little or None
2 - 4	Borderline
5 - 8	Mild
9 - 12	Moderate
13 - 16	Severe
17 - 20	Extreme

Score	Relationship Satisfaction
0 - 10	extremely dissatisfied
11 - 15	very dissatisfied
16 - 20	moderately dissatisfied
21 - 25	marginal
26 - 28	moderately satisfied
29 - 30	completely satisfied

# The SF-36v2™ Health Survey

## Instructions for Completing the Questionnaire

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by filling in the bubble that best represents your response.

### EXAMPLE

**This is for your review.** Do not answer this question. The questionnaire begins with the section *Your Health in General* below.

For each question you will be asked to fill in a bubble in each line:

1. How strongly do you agree or disagree with each of the following statements?

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
a) I enjoy listening to music.	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) I enjoy reading magazines.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please begin answering the questions now.

## Your Health in General

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. 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 as one year ago	Somewhat worse now than one year ago	Much worse now than one year ago
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*Please turn the page and continue.*

3. 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?

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

- |                                                                                                            |                       |                       |                       |
|------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|
| a) <b>Vigorous activities</b> , such as running, lifting heavy objects, participating in strenuous sports  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b) <b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c) Lifting or carrying groceries                                                                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d) Climbing <b>several</b> flights of stairs                                                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e) Climbing <b>one</b> flight of stairs                                                                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f) Bending, kneeling, or stooping                                                                          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g) Walking <b>more than a mile</b>                                                                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h) Walking <b>several hundred yards</b>                                                                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i) Walking <b>one hundred yards</b>                                                                        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| j) Bathing or dressing yourself                                                                            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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

All of the time	Most of the time	Some of the time	A little of the time	None of the time
--------------------	---------------------	---------------------	-------------------------	---------------------

- |                                                                                                      |                       |                       |                       |                       |                       |
|------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a) Cut down on the <b>amount of time</b> you spent on work or other activities                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b) <b>Accomplished less</b> than you would like                                                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c) Were limited in the <b>kind</b> of work or other activities                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d) Had <b>difficulty</b> performing the work or other activities (for example, it took extra effort) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

5. During the **past 4 weeks**, how much of the time 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)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
--------------------	---------------------	---------------------	-------------------------	---------------------

- |                                                                                |                       |                       |                       |                       |                       |
|--------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a) Cut down on the <b>amount of time</b> you spent on work or other activities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b) <b>Accomplished less</b> than you would like                                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c) Did work or other activities <b>less carefully</b> than usual               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

6. 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
- 

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

- None                      Very mild                      Mild                      Moderate                      Severe                      Very severe
- 

8. 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
- 

9. 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. How much of the time during the **past 4 weeks**...

All of the time	Most of the time	Some of the time	A little of the time	None of the time
-----------------	------------------	------------------	----------------------	------------------

- |                                                                   |                       |                       |                       |                       |                       |
|-------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a) did you feel full of life?                                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b) have you been very nervous?                                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c) have you felt so down in the dumps nothing could cheer you up? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d) have you felt calm and peaceful?                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e) did you have a lot of energy?                                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f) have you felt downhearted and depressed?                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g) did you feel worn out?                                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h) have you been happy?                                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i) did you feel tired?                                            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

10. 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.)?

- All of the time                      Most of the time                      Some of the time                      A little of the time                      None of the time
- 

11. How TRUE or FALSE is each of the following statements for you?

Definitely true	Mostly true	Don't know	Mostly false	Definitely false
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|---------------------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a) I seem to get sick a little easier than other people | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b) I am as healthy as anybody I know                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c) I expect my health to get worse                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d) My health is excellent                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!**