



23290



# North Staffordshire Health Study

**Version 4.0, 02May2017**

**REC Reference: 15/NW/0735**

This research project is funded by Arthritis Research UK



23290

### INSTRUCTIONS FOR COMPLETION

The aim of this study is to find out about your health and how it impacts on activities of daily life. The answers you give in the questionnaire will be treated in the **strictest confidence**.

**Please answer even if you have no problems with your health.**

Please answer all of the questions unless the instructions ask you to do something else.

Please write in **BLACK PEN** and **BLOCK CAPITALS** where appropriate.

Most of the questions can be answered by putting a cross in a box like this:



For example: *How confident are you at completing forms by yourself?*

Not confident											Very confident
	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**When you have finished please check that you have answered all of the questions and then return the questionnaire in the pre-paid envelope enclosed. You do not need a stamp. Please return the completed questionnaire within the next two weeks.**

More details about this study are available in the Participant Information Sheet enclosed.

If you would like further information about this study, please contact the North Staffordshire Health Study co-ordinator on 01782 734721.

**Thank you for your help with this research study.**



**SECTION A: YOUR GENERAL HEALTH**

**PART 1**

We are interested in your general health. Under each heading, please cross the ONE box that best describes your health **TODAY**

**a. MOBILITY**

- I have no problems in walking about.....
- I have slight problems in walking about.....
- I have moderate problems in walking about.....
- I have severe problems in walking about.....
- I am unable to walk about.....

**b. SELF-CARE**

- I have no problems washing or dressing myself.....
- I have slight problems washing or dressing myself.....
- I have moderate problems washing or dressing myself.....
- I have severe problems washing or dressing myself.....
- I am unable to wash or dress myself.....

**c. USUAL ACTIVITIES** (e.g. work, study, housework, family or leisure activities)

- I have no problems doing my usual activities.....
- I have slight problems doing my usual activities.....
- I have moderate problems doing my usual activities.....
- I have severe problems doing my usual activities.....
- I am unable to do my usual activities.....

**d. PAIN / DISCOMFORT**

- I have no pain or discomfort.....
- I have slight pain or discomfort.....
- I have moderate pain or discomfort.....
- I have severe pain or discomfort.....
- I have extreme pain or discomfort.....

**e. ANXIETY / DEPRESSION**

- I am not anxious or depressed.....
- I am slightly anxious or depressed.....
- I am moderately anxious or depressed.....
- I am severely anxious or depressed.....
- I am extremely anxious or depressed.....



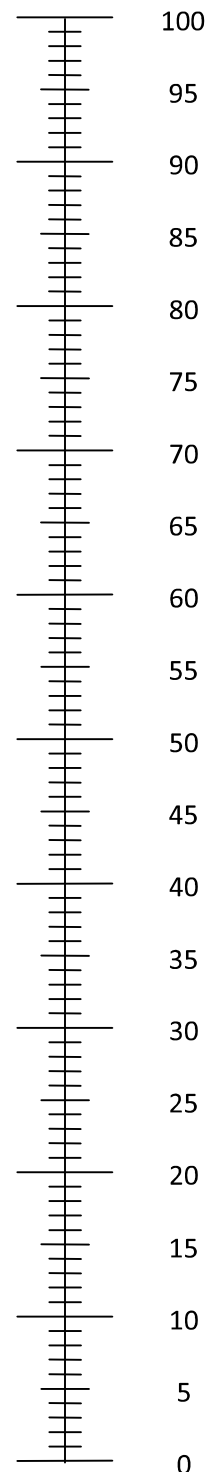
23290

We would like to know how good or bad your health is TODAY.

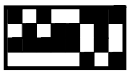
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.  
0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

**YOUR HEALTH TODAY =**

The best health  
you can imagine



The worst health  
you can imagine



23290

### PART 2

These questions are about PAIN. Please complete each of the following questions **even if you have not suffered pain.**

- |   | Never                    | Some days                | Most days                | Every day                |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. In the <b>past 6 months</b> , how often did you have pain?                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Over the <b>past 6 months</b> , how often did pain limit your life or work activities? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

These questions are about **HOW OFTEN** you have had pain in different parts of the body in the **last 6 months**. Please complete each of the following questions even if you have not suffered pain in any of these areas.

3. On how many days in the **last 6 months** have you had.....?  
*(For each pain, please put a cross in one box)*

- |                           | Never                    | Some days                | Most days                | Every day                |
|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Neck pain.....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Shoulder pain.....     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hand / wrist pain..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Back pain.....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Hip pain.....          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Knee pain .....        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Foot / ankle pain..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



23290

**These next questions are about pain in the PAST 2 WEEKS.**

**4. In the past 2 weeks, on average, how intense were each of these pains rated on a 0-10 scale where 0 is "no pain" and 10 is "pain as bad as could be"? (That is, your usual pain at times you were experiencing pain.)**

***For each pain, please put a cross in one box. For pains that do not apply to you please put a cross in box 0 to indicate No Pain.***

	<b>No pain</b>										<b>Pain as bad as could be</b>	
	0	1	2	3	4	5	6	7	8	9	10	
a. Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Hand / wrist pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Hip pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Knee pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Foot / ankle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



23290

These questions are about any **joint, back, neck, bone and muscle symptoms** such as aches, pains and / or stiffness that you may have. Please complete each of the following questions **even if you have not suffered pain in any of these areas.**

For each question **cross (X) one box** to indicate which statement best describes you.

**5. Pain / stiffness during the day**

How severe was your usual joint or muscle pain and / or stiffness overall during the **day** in the last 2 weeks?

Not at all	Slightly	Moderately	Fairly severe	Very severe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6. Pain / stiffness during the night**

How severe was your usual joint or muscle pain and / or stiffness overall during the **night** in the last 2 weeks?

Not at all	Slightly	Moderately	Fairly severe	Very severe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**7. Walking**

How much have your symptoms interfered with your ability to walk in the last 2 weeks?

Not at all	Slightly	Moderately	Severely	Unable to walk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8. Washing / Dressing**

How much have your symptoms interfered with your ability to wash or dress yourself in the last 2 weeks?

Not at all	Slightly	Moderately	Severely	Unable to wash or dress myself
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**9. Physical activity levels**

How much has it been a problem for you to do physical activities (e.g. going for a walk or jogging) to the level you want because of your joint or muscle symptoms in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Unable to do physical activities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



23290

**10. Work / daily routine**

How much have your joint or muscle symptoms interfered with your work or daily routine in the last 2 weeks (including work & jobs around the house)?

Not at all	Slightly	Moderately	Severely	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**11. Social activities and hobbies**

How much have your joint or muscle symptoms interfered with your social activities and hobbies in the last 2 weeks due to joint pain?

Not at all	Slightly	Moderately	Severely	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**12. Needing help**

How often have you needed help from others (including family, friends or carers) because of your joint or muscle symptoms in the last 2 weeks?

Not at all	Rarely	Sometimes	Frequently	All the time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**13. Sleep**

How often have you had trouble with either falling asleep or staying asleep because of your joint or muscle symptoms in the last 2 weeks?

Not at all	Rarely	Sometimes	Frequently	Every night
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**14. Fatigue or low energy**

How much fatigue or low energy have you felt in the last 2 weeks?

Not at all	Slight	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





23290

**15. Emotional well-being**

How much have you felt anxious or low in your mood because of your joint or muscle symptoms in the last 2 weeks?

Not at all	Slightly	Moderately	Severely	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**16. Understanding of your condition and any current treatment**

Thinking about your joint or muscle symptoms, how well do you feel you understand your condition and any current treatment (including your diagnosis and medication)?

Completely	Very well	Moderately	Slightly	Not at all
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**17. Confidence in being able to manage your symptoms**

How confident have you felt in being able to manage your joint or muscle symptoms by yourself in the last 2 weeks (e.g. medication, changing lifestyle)?

Extremely	Very	Moderately	Slightly	Not at all
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**18. Overall impact**

How much have your joint or muscle symptoms bothered you overall in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**19. Physical activity levels**

**In the past week**, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your heart rate? *This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that is part of your job.*

None	1 day	2 days	3 days	4 days	5 days	6 days	7 days
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**PART 3**

These questions are about how you may manage your pain.

**1. In the last month, have you bought any of the following medicines for your pain from the pharmacy or supermarket that were not prescribed by a doctor. (Please cross one box for each)**

	<b>Yes</b>	<b>No</b>
a. Paracetamol.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Anti-inflammatory tablets (e.g. Ibuprofen, Naproxen).....	<input type="checkbox"/>	<input type="checkbox"/>
c. Co-codamol .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Glucosamine / Chondroitin sulphate.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Anti-inflammatory creams, gels, rub-ons, sprays (e.g. Emugel, Feldene, Ibuleve, Movelat, Traxam).....	<input type="checkbox"/>	<input type="checkbox"/>

**2. In the last 6 months, have you seen any of these health care professionals for your pains.**

	<b>Yes</b>	<b>No</b>
a. Consultant / hospital specialist.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Physiotherapist.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Hospital nurse.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Chiropractor OR Osteopath.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Acupuncturist.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Other (please specify below).....	<input type="checkbox"/>	<input type="checkbox"/>

.....



23290

**PART 4**

We would like to know if you have any other health problems.  
For each question, **please put a cross in one box.**

- |  | <b>Yes</b>               | <b>No</b>                | <b>Not sure</b>          |
|--|--------------------------|--------------------------|--------------------------|
| 1. Do you have high blood pressure?.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you received blood pressure treatment?.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you suffer from diabetes?.....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a chronic kidney disease?.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you suffered from atrial fibrillation?.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have rheumatoid arthritis?.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever suffered from cardiovascular disease?.....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does a close relative under 60 suffer from cardiovascular disease?.....                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been diagnosed / told by a doctor that you have osteoarthritis ('wear and tear' arthritis)?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

10. Please respond by putting a **cross in one box** for each statement.

- |  | <b>Never</b>             | <b>Rarely</b>            | <b>Sometimes</b>         | <b>Usually</b>           | <b>Always</b>            |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. I have trouble doing all of my regular leisure activities with others     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I have trouble doing all of the family activities that I want to do       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I have trouble doing all of my usual work (include work at home)          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I have trouble doing all of the activities with friends that I want to do | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

11. Please respond by putting a **cross in one box** for each question.

- |   | <b>Without any difficulty</b> | <b>With a little difficulty</b> | <b>With some difficulty</b> | <b>With much difficulty</b> | <b>Unable to do</b>      |
|---|-------------------------------|---------------------------------|-----------------------------|-----------------------------|--------------------------|
| a. Are you able to do chores such as vacuuming and gardening? | <input type="checkbox"/>      | <input type="checkbox"/>        | <input type="checkbox"/>    | <input type="checkbox"/>    | <input type="checkbox"/> |
| b. Are you able to go up and down stairs at a normal pace?    | <input type="checkbox"/>      | <input type="checkbox"/>        | <input type="checkbox"/>    | <input type="checkbox"/>    | <input type="checkbox"/> |
| c. Are you able to go for a walk of at least 15 minutes?      | <input type="checkbox"/>      | <input type="checkbox"/>        | <input type="checkbox"/>    | <input type="checkbox"/>    | <input type="checkbox"/> |
| d. Are you able to get out and about or go shopping?          | <input type="checkbox"/>      | <input type="checkbox"/>        | <input type="checkbox"/>    | <input type="checkbox"/>    | <input type="checkbox"/> |



23290

12. Thinking back over the **past 4 weeks**, did you....?  
*(Please put a cross in one box on each line)*

**Not  
at all**

**On  
some  
nights**

**On  
most  
nights**

- a. Have trouble falling asleep.....
- b. Wake up several times per night.....
- c. Have trouble staying asleep.....
- d. Wake up after your usual amount of sleep feeling tired  
and worn out.....

13. These are questions about how it is for you to find, understand and use information related to health, illness and medical care. **Place a cross in the box on each line that best matches your answer**

**How easy / difficult is it for you to....**

**Very  
easy**

**Easy**

**Difficult**

**Very  
difficult**

- a. Judge when you need to get a second opinion from another doctor?
- b. Use information the doctor gives you to make decisions about your illness?
- c. Find information on how to manage mental health problems such as stress and depression?
- d. Judge if the information on health risks in the media is reliable (e.g. from TV or internet)?
- e. Find out about activities that are good for your mental well-being (e.g. meditation, exercise and walking)?
- f. Understand information in the media on how to get healthier (e.g. from the internet, daily or weekly magazines)?

g. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

**Never**

**Rarely**

**Sometimes**

**Often**

**Always**

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23290

**PART 5**

The following questions are about how you feel at the moment. Please read each item and put a cross next to the reply that comes closest to how you have been feeling **in the past week**. Don't take too long over your replies: your immediate reaction to each item will usually be more accurate than a long thought out response.

1. I feel tense or 'wound up':

Most of the time

A lot of the time

From time to time, occasionally

Not at all

2. I still enjoy the things I used to enjoy:

Definitely as much

Not quite as much

Only a little

Hardly at all

3. I get a sort of frightened feeling as if something awful is about to happen:

Very definitely and quite badly

Yes, but not too badly

A little, but it doesn't worry me

Not at all

4. I can laugh and see the funny side of things:

As much as I always could

Not quite so much now

Definitely not so much now

Not at all

5. Worrying thoughts go through my mind:

A great deal of the time

A lot of the time

Not too often

Very little

6. I feel cheerful:

Never

Not often

Sometimes

Most of the time

7. I can sit at ease and feel relaxed:

Definitely

Usually

Not often

Not at all



23290

8. I feel as if I am slowed down:

Nearly all the time

Very often

Sometimes

Not at all

9. I get a sort of frightened feeling like 'butterflies' in my stomach:

Not at all

Occasionally

Quite often

Very often

10. I have lost interest in my appearance:

Definitely

I don't take as much care as I should

I may not take quite as much care

I take just as much care as ever

11. I feel restless as if I have to be on the move:

Very much indeed

Quite a lot

Not very much

Not at all

12. I look forward with enjoyment to things:

As much as I ever did

Rather less than I used to

Definitely less than I used to

Hardly at all

13. I get sudden feelings of panic:

Very often indeed

Quite often

Not very often

Not at all

14. I can enjoy a good book or radio or television programme:

Often

Sometimes

Not often

Very seldom



**SECTION B: LIFESTYLE**

1. What is your weight?  st  lbs or  kgs

2. What is your height?  ft  in or  cms

3. Pick the description that matches you best.....

I have never smoked.....

I am a former smoker (last smoked more than 12 months ago).....

I am a current smoker or I smoked regularly in the last 12 months and I smoke .....

1-5 cigarettes / day.....

6-10 cigarettes / day.....

11-15 cigarettes / day.....

16-20 cigarettes / day.....

More than 20 cigarettes / day.....

4. About how often do you drink alcohol?  
*(Please put a cross in one box only)*

Daily or almost daily	3 or 4 times a week	Once or twice a week	1 to 3 times a month	Special occasions only	Never
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

↓  
Please go to question 7.

5. In an **average week** how many.....

**Number**

a. **regular** (175ml) glasses of **wine** would you drink?  
*(there are roughly four regular glasses in an average bottle)*

b. pints of **beer** or **cider** would you drink?  
*(includes bitter, lager, stout, ale, Guinness)*

c. **single** measures (25ml) of **spirits or liqueurs** would you drink? *(includes drinks such as whisky, gin, vodka)*

6. Compared to 10 years ago, do you drink.....

More nowadays	About the same	Less nowadays	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



23290

**7. Please tell us the type and amount of physical activity involved in your work. Please cross one box only.**

- a. I am not in employment (e.g. retired, retired on health reasons, unemployed, full-time carer etc.)
- b. I spend most of my time at work sitting (such as in an office)
- c. I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)
- d. My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)
- e. My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)

**8. During the last week, how many hours did you spend on each of the following? (Please answer whether you are in employment or not)**

	None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
a. Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Cycling, including cycling to work and during leisure time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Walking, including walk to work, shopping, for pleasure etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Housework / Childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Gardening / DIY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**9. How would you describe your usual walking pace? (Please cross one box only)**

- |                                     |                          |                          |                                |
|-------------------------------------|--------------------------|--------------------------|--------------------------------|
| Slow pace<br>(i.e. less than 3 mph) | Steady average pace      | Brisk pace               | Fast pace<br>(i.e. over 4 mph) |
| <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>       |





[Empty box for identification number]

**SECTION C: ABOUT YOU AND YOUR CIRCUMSTANCES**

This section contains general questions about yourself and your circumstances. Please follow the instructions and answer ALL of the questions relevant to you.

1. What is your date of birth? [ ][ ] / [ ][ ] / [ ][ ]

(For example - if you were born on the 5th of June 1936, this would be entered as 05/06/36)

2. Are you: Female  Male

3. What is your ethnic group?  
*(Please put a cross in one box only)*

- White
- Black-Other
- Bangladeshi
- Black-Caribbean
- Indian
- Chinese
- Black-African
- Pakistani
- Other (please specify).....

4. How old were you when you left school? [ ][ ] years old

Yes No

5. Did you go on from school to full-time education or university?

6. Do you have any of the following qualifications? *(Cross all boxes that apply)*

- a) O Levels / GCSEs (or equivalents)
- b) A Levels (or equivalents)
- c) Vocational training certificate(s) (e.g. City and Guilds, NVQ)
- d) University degree(s) or HND
- e) Higher professional qualifications (e.g. in accountancy, law, etc.)

7. What is your current marital status?  
*(Please put a cross in one box only)*

- Married
- Separated
- Divorced
- Widowed
- Cohabiting
- Single



23290

8. Thinking about the cost of living as it affects you, which of these descriptions best describes your situation. **(Please put a cross in one box only)**

Find it a strain to get by from week to week	Have to be careful with money	Able to manage without much difficulty	Quite comfortably off
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. How often have you felt work or home life stress in the last year?

Never	Some periods	Several periods of stress	Permanent stress
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Use the following scale and put a cross in the box for each statement to indicate how much you disagree or agree with each of the statements. **(Please put a cross in one box only on each line)**

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
a. I tend to bounce back quickly after hard times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I have a hard time making it through stressful events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. It does not take me long to recover from a stressful event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. It is hard for me to snap back when something bad happens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I usually come through difficult times with little trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I tend to take a long time to get over set-backs in my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. What is your current employment status? **(Please put a cross in one box only)**

In paid employment or self-employed	Unable to work because of sickness or disability	Retired	Unemployed / seeking work	Looking after home and / or family	Doing unpaid or voluntary work	Full or part-time student	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



23290

12. If you are **working** what is your job title?  
(examples - factory worker, welder, office worker, lawyer)

13. If you provided a job title in the question above please state in which field of employment this is  
(examples - manufacturing, civil service, health care)

14. If you are **not working** or **retired** what job have you done for **most** of your working life?  
(examples - factory worker, welder, office worker, lawyer)

15. If you provided a job title in the question above please state in which field of employment this was  
(examples - manufacturing, civil service, health care)

16. Do you look after, or give any help or support to family members, friends, neighbours or others because of either:- **long-term physical or mental ill-health / disability? problems related to old age?**  
*Do not count anything you do as part of paid employment*

- |                          |                           |                            |                                   |
|--------------------------|---------------------------|----------------------------|-----------------------------------|
| No                       | Yes,<br>1-19 hours a week | Yes,<br>20-49 hours a week | Yes,<br>50 or more hours per week |
| <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/>          |

These questions are about **your current work**. If you are not working, please **go to SECTION D**.

17. How would you best describe your **typical working week** in the **last 12 months?**

- |  |  |
|--|--|
| Working full-time<br>(30 hours or more per week) | Working part-time<br>(29 hours or less per week) |
| <input type="checkbox"/>                         | <input type="checkbox"/>                         |

18. How satisfied are you with your employment?

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Very satisfied           | Satisfied                | No opinion               | Not very satisfied       | Not at all satisfied     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



23290

19. During the past seven days, how many hours did you miss from work because of your health problems? *Include hours you missed on sick days, times you went in late, left early, etc., because of your health problems.*

 hours

20. During the past seven days, how many hours did you miss from work because of any other reason, such as vacation, holidays, time off to participate in this study?

 hours

21. During the past seven days, how many hours did you actually work?

 hours

22. During the past seven days, how much did your health problems affect your productivity while you were working?

*Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If health problems affected your work only a little, choose a low number. Choose a high number if health problems affected your work a great deal*

Consider only how much health problems affected productivity while you were working

	0	1	2	3	4	5	6	7	8	9	10	
Health problems had no effect on my work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Health problems completely prevented me from working

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Data Entry	Quality Checked



23290

**SECTION D: CONTINUING TO HELP WITH THIS STUDY**

**Thank you very much for completing this questionnaire.**

Please ensure that you have read the enclosed Participant Information Sheet (version 3.1 dated 23-May-2017) that explains about the study.

By completing and returning this questionnaire, you confirm that you have read and understood the Participant Information Sheet and are willing to take part in the study.

You can withdraw from the study at any time, and this will not affect the care you receive in any way.

**Consent form**

As well as completing this questionnaire, we would like your permission to review your medical records and results of previous studies as part of this study. More details on this can be found in the Participant Information Sheet.

**Even if you would prefer us not to review your medical records or link this information to that from previous questionnaires, the answers you have given in this questionnaire will still be very important to us.**

**Please read and complete the following consent form, and then sign below.  
Please answer each statement by putting a cross in the box on each line.**

	Yes	No
I give my permission for my medical records to be reviewed for this study.....	<input type="checkbox"/>	<input type="checkbox"/>
I give my permission for the information collected in this questionnaire to be linked to the information I gave in similar previous questionnaires from Keele University (if applicable) .....	<input type="checkbox"/>	<input type="checkbox"/>
I am happy to be contacted about future research studies (this does not mean that you must take part in future - you are just agreeing to be contacted again) .....	<input type="checkbox"/>	<input type="checkbox"/>

Signed: ..... Date: .....

**Please print your name and address:**

Title: ..... Forename: ..... Surname: .....

Address: .....

..... Town/City: .....

County: ..... Postcode: .....

Telephone number: .....

**Please return your questionnaire in the pre-paid envelope provided (no stamp needed).**

**Thank you for your help with this research study.**



23290

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