



# SJLIFE

## Behavior Survey

Finding cures. Saving children.

The questions in this booklet relate to:

**Name**

Person completing this questionnaire is:

Your relationship:

1  Self 2  Parent 3  Other:    
**relation**

Today's date:

/   /       
**m m d d y y y y**  
**datecomp**

**Our mailing address is:**  
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STUDYNAME

Please! Do not mark below this line

MRN

Survey #314

9487394015

## LIVING/MARITAL STATUS

A1. What is your current living arrangement? **curliv**  
(Mark all that apply)

- Live with spouse/partner **curliv\_spo**
- Live with parent(s) **curliv\_par**
- Live with roommate(s) **curliv\_rm**
- Live with brother(s) and/or sister(s) **curliv\_sib**
- Live with other relative(s) (not including minor children) **curliv\_rel**
- Live alone **curliv\_aln**

Other **curliv\_oth**

Specify.

**msspec** text

A2. Have you ever been married or had a live-in relationship (lived as married)? **everm**

- 2  No → **Go to Question B1a.**
- 1  Yes

A3. Which of the following best describes your current marital status? **curms**

- 0  Single, never married or never lived with partner as married → **Go to Question B1a.**
- 1  Married
- 2  Living with a partner as married
- 3  Widowed
- 4  Divorced
- 5  Separated or no longer living as married

A4. How many times have you been married or lived as married? **marnu**

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9+                       |
| <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>1</b>                 | <b>2</b>                 | <b>3</b>                 | <b>4</b>                 | <b>5</b>                 | <b>6</b>                 | <b>7</b>                 | <b>8</b>                 | <b>9</b>                 |

A5. How old were you at the time of your first marriage or when you first began living as married? **marage**

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## SCHOOL HISTORY

B1a. What is the highest grade or level of schooling that you have completed? **grade**

- 1  1 - 8 years (grade school)
- 2  9 - 12 years (high school), but did not graduate
- 3  Completed high school/GED
- 4  Training after high school, other than college
- 5  Some college
- 6  College graduate
- 7  Post-graduate level
- 8  Other

Specify.

**gradespe** text

B1b. What is the highest grade or level of schooling that your mother has completed? **gradem**

- 1  1 - 8 years (grade school)
- 2  9 - 12 years (high school), but did not graduate
- 3  Completed high school/GED
- 4  Training after high school, other than college
- 5  Some college
- 6  College graduate
- 7  Post-graduate level
- 9  Not Applicable
- 10  Unknown
- 8  Other

Specify.

**grdmspe** text

Please! Do not mark below this line

**B1c. What is the highest grade or level of schooling that your father has completed? *grdef***

- 1  1 - 8 years (grade school)
- 2  9 - 12 years (high school), but did not graduate
- 3  Completed high school/GED
- 4  Training after high school, other than college
- 5  Some college
- 6  College graduate
- 7  Post-graduate level
- 9  Not Applicable
- 10  Unknown
- 8  Other

**Specify.**

*grdfspe* *text*

**B2. If you have completed high school, did you receive a regular high school diploma or did you receive a high school equivalency certificate, also called a GED? *ged***

- 1  High school diploma
- 2  GED

**B3. In elementary, junior, or high school were you ever in any of the following programs? (Mark all that apply)**

	3 Not sure	1 Yes	2 No
Learning disabled or special education program? . . . . . <i>speced</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>If yes, were you in the program because of. . .</b>			
a. Missed school. . . . . <i>speced_a</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Low scores on tests. . . . . <i>speced_b</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Problems learning or concentrating. . . <i>speced_c</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Emotional or behavioral problems. . . . <i>speced_d</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advanced placement or talented program? . . . <i>adplc</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homebound education for at least one school year due to a medical reason? . . . . <i>homed</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B4. If you were in a learning disabled or special education program, what grades were you in at that time? (Mark all that apply) *specprog***

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> K<br><i>specprog_k</i>   | <input type="checkbox"/> 5th<br><i>specprog_5</i> | <input type="checkbox"/> 9th<br><i>specprog_9</i>   |
| <input type="checkbox"/> 1st<br><i>specprog_1</i> | <input type="checkbox"/> 6th<br><i>specprog_6</i> | <input type="checkbox"/> 10th<br><i>specprog_10</i> |
| <input type="checkbox"/> 2nd<br><i>specprog_2</i> | <input type="checkbox"/> 7th<br><i>specprog_7</i> | <input type="checkbox"/> 11th<br><i>specprog_11</i> |
| <input type="checkbox"/> 3rd<br><i>specprog_3</i> | <input type="checkbox"/> 8th<br><i>specprog_8</i> | <input type="checkbox"/> 12th<br><i>specprog_12</i> |
| <input type="checkbox"/> 4th<br><i>specprog_4</i> |   |   |

**B5. Were you ever home schooled unrelated to medical issues? *homesch***

- 1  Yes
- 2  No
- 3  Unsure

*Continue on next page.*

Please! Do not mark below this line

# EMPLOYMENT HISTORY

C1. Have you ever had a job? **evjob**

2  No → Go to Question C4.

1  Yes

C2. What is your current employment status? Include unpaid work in the family business or farm. **empst**  
(Mark all that apply)

- Not currently working **empst\_not**
- Working full-time (30 or more hours per week) **empst\_full**
- Working part-time (less than 30 hours per week) **empst\_par**
- Caring for home or family (not seeking paid work) **empst\_care**
- Unemployed and looking for work **empst\_look**
- Unable to work due to illness or disability **empst\_dis**
- Retired **empst\_retire**
- Student **empst\_std**

Other **Specify.**  
**empst\_oth**

**empst\_oth** text

C3. The following questions are about your present occupation. Please write your job title and brief details of what you do. If you have more than one job, please give the title of your main job (please give only one):

C3a. Main job title:

**mainj** text

C3b. Please briefly describe the primary tasks in your job:

**no entry**

C4. Have you ever applied for entry into the following services?

		2 No	1 Yes
Military (Army, Navy, etc.) . . . . . <b>military</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Police Department . . . . . <b>police</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire Department. . . . . <b>fire</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C5. Have you ever not gotten a job or into military service because of your previous medical history?

Civilian job . . . . . <b>nocivil</b>	<input type="checkbox"/>	<input type="checkbox"/>
Military (Army, Navy, etc.) . . . . . <b>nomil</b>	<input type="checkbox"/>	<input type="checkbox"/>
Police Department . . . . . <b>nopol</b>	<input type="checkbox"/>	<input type="checkbox"/>
Fire Department. . . . . <b>nofire</b>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

## INCOME

D1. Over the last year, what was the total income of the household you live in? **homeinc**

- 1  Less than \$20,000
- 2  \$20,000 - \$39,999
- 3  \$40,000 - \$59,999
- 4  \$60,000 - \$79,999
- 5  \$80,000 - \$99,999
- 6  Over \$100,000
- 9  Don't know

D2. During the past year, how many people in this household were supported on this income? **incsupn**

- 1  1
- 2  2
- 3  3
- 4  4
- 5  5
- 6  6
- 7  7
- 8  8
- 9  9 or more

D3. Over the last year, what was your personal income? **perinc**

- 1  None
- 2  Less than \$20,000
- 3  \$20,000 - \$39,999
- 4  \$40,000 - \$59,999
- 5  \$60,000 - \$79,999
- 6  \$80,000 - \$99,999
- 7  Over \$100,000

D4. In the last 12 months, how have your finances usually worked out at the end of the month? **endmo**

- 1  Some money left over
- 2  Just enough to make ends meet
- 3  Not enough to make ends meet

D5. In the past 12 months, was there ever a time when you did not have enough money to pay your monthly bills? **bills**

- 1  Yes, a lot of times I did not have enough money to pay my monthly bills
- 2  Yes, a few times when I did not have enough money to pay my monthly bills
- 3  No, I always had enough money to pay my monthly bills

D6. In the past 12 months, was there a time you needed to see a doctor or go to the hospital but did not go due to finances? **needdr1**

- 2  No
- 1  Yes

D7. In the past 12 months, was there a time anyone in your household (other than you) needed to see a doctor or go to the hospital but did not go due to finances? **needdr2**

- 2  No
- 1  Yes

*Continue on next page.*

# INSURANCE

## Health Insurance

E1. Have you ever had difficulty obtaining health insurance because of your health history? **hlins**

- 2  No
- 1  Yes

E2. Do you currently have health insurance coverage? **hltcov**

- 3  Non - U.S. resident/citizen **→ Go to Question E4.**
- 2  No **→ Go to Question E4.**
- 1  Yes

E3. How is this insurance provided? (Mark all that apply) **insprv**

- Through your place of employment/education **insprv\_epm**
- Through your spouse's or parent's policy **insprv\_spo**
- Through a policy you have purchased yourself **insprv\_sel**
- Affordable Care Act (Obama Care) **insprv\_aca**
- Medicaid or other public assistance program **insprv\_pub**
- Medicare **insprv\_med**
- Military dependent/Veteran's benefits (CHAMPUS) **insprv\_mil**

Other **insprv\_oth**

**Specify.**  
**insspe** **text**

E3a. Does this health insurance plan have any exclusions or restrictions because of your health history? **insexc**

- 3  Don't know
- 2  No
- 1  Yes

**Specify.**  
**insexsp**  
**text**

E3b. Is there an extra premium charge on your health insurance policy because of your health history? **insext**

- 3  Don't know
- 2  No
- 1  Yes

## Life Insurance

E4. Have you ever had difficulty obtaining life insurance because of your health history? **lifins**

- 2  No
- 1  Yes
- 3  Never tried to obtain life insurance

E5. Do you currently have life insurance coverage? **lifcov**

- 2  No **→ Go to Question F1, next page.**
- 1  Yes

**E6. How is this life insurance provided?** *life*  
(Mark all that apply)

- Through your employer *life\_emp*
- Through your spouse's or parent's policy *life\_spo*
- Through a policy you have purchased yourself *life\_sel*
- Other *life\_oth*

**Specify.**

*lifspe*  
text

**E6a. Does this life insurance plan have any exclusions or restrictions?** *lifexc*

- Don't know
- No
- Yes

**Specify.**

*lifexp*  
text

**E6b. Is there an extra premium charge on your life insurance policy because of your health history?** *lifext*

- Don't know
- No
- Yes

**E6c. What is the total dollar value of your life insurance policy(ies)?** *lifval*

- Under \$10,000
- \$10,000 - \$49,999
- \$50,000 - \$99,999
- \$100,000 or more
- Don't know

## SLEEP

Questions F1 to F8 relate to the past 7 days.

						<b>Very much</b>
						<b>Quite a bit</b>
						<b>Somewhat</b>
						<b>A little bit</b>
						<b>Not at all</b>
F1. My sleep was restless . . . . .	<i>slprstl</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3	4	5
F2. I was satisfied with my sleep . . . . .	<i>slpsat</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		5	4	3	2	1
F3. My sleep was refreshing. . . . .	<i>slpref</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		5	4	3	2	1
F4. I had difficulty falling asleep. . . . .	<i>slpdif</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3	4	5

						<b>Always</b>
						<b>Often</b>
						<b>Sometimes</b>
						<b>Rarely</b>
						<b>Never</b>
F5. I had trouble staying asleep . . . . .	<i>slpstay</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3	4	5
F6. I had trouble sleeping . . . . .	<i>slptrb</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3	4	5
F7. I got enough sleep. . . . .	<i>slpengh</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		5	4	3	2	1

						<b>Very good</b>
						<b>Good</b>
						<b>Fair</b>
						<b>Poor</b>
						<b>Very poor</b>
F8. My sleep quality was . . . . .	<i>slpqual</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		5	4	3	2	1

Please! Do not mark below this line

# FATIGUE

Questions G1 to G19 relate to the past 7 days.

4 Very much

3 Quite a bit

2 Somewhat

1 A little bit

0 Not at all

G1. I feel fatigued .....	<b>ffatig</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G2. I feel weak all over .....	<b>fweak</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G3. I feel listless ("washed out") .....	<b>flist</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G4. I feel tired .....	<b>ftired</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G5. I have trouble <u>starting</u> things because I am tired .....	<b>fstart</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G6. I have trouble <u>finishing</u> things because I am tired .....	<b>ffin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G7. I have energy .....	<b>fenergy</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G8. I am able to do my usual activities .....	<b>fusual</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G9. I need to sleep during the day .....	<b>fsleep</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G10. I am too tired to eat .....	<b>feat</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G11. I need help doing my usual activities .....	<b>fhelp</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G12. I am frustrated by being too tired to do the things I want to do .....	<b>ffrust</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G13. I have to limit my social activity because I am tired .....	<b>fsocial</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# PAIN INTERFERENCE

G14. How much did pain interfere with your day to day activities? .....	<b>pn<sub>day</sub></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G15. How much did pain interfere with work around the home? .....	<b>pn<sub>home</sub></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G16. How much did pain interfere with your ability to participate in social activities? .....	<b>pn<sub>social</sub></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G17. How much did pain interfere with your household chores? .....	<b>pn<sub>chore</sub></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G18. How much did pain interfere with the things you usually do for fun? .....	<b>pn<sub>fun</sub></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G19. How much did pain interfere with your enjoyment of social activities? .....	<b>pn<sub>act</sub></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**G20. Do you currently have pain as a result of your cancer or similar illness, or its treatment? **capain****

- 1  No pain
- 2  Small amount of pain
- 3  Medium amount of pain
- 4  A lot of pain
- 5  Very bad, excruciating pain

**G21. Do you have any persisent or recurrent pain, more than aches and pains that are fleeting and minor?**

- 2  No → Go to Question H1, next page. **recurrentpain**
- 1  Yes

**G21a. If yes, how long have you been experiencing this pain? **longpain****

- 1  Less than 1 month
- 2  1-2 months
- 3  3-4 months
- 4  5-6 months
- 5  More than 6 months
- 6  Other other\_pain

Please! Do not mark below this line



## SOCIAL BEHAVIOR

For questions H1 to H12, please respond to each item by marking one box per row.

		1 Never	2 Rarely	3 Sometimes	4 Usually	5 Always
H1. Do you have someone to help you if you are confined to bed? .....	shelp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H2. Do you have someone to take you to the doctor if you need it? .....	sdr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H3. Do you have someone to help with your daily chores if you are sick? .....	schore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H4. Do you have someone to run errands if you need it? .....	serrand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H5. Do you have someone to prepare your meals if you are unable to do it yourself? .....	smeal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H6. Do you have someone to take over all of your responsibilities at home if you need it? .....	sresp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H7. I feel left out .....	sleftout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H8. I feel that people barely know me. ....	sknow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H9. I feel isolated from others. ....	sisol1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H10. I feel that people are around me but not with me. ....	sisol2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H11. I feel isolated even when I am not alone. ....	sisol3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H12. I feel that people avoid talking to me. ....	savoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Questions H13 to H20 relate to the past 7 days.

		1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
H13. I had trouble controlling my temper .....	temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H14. It was hard to control my behavior .....	behave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H15. I said or did things without thinking. ....	think	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H16. I got impatient with other people. ....	impact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H17. I was irritable around other people. ....	irrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H18. I was bothered by little things. ....	bother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H19. I became easily upset. ....	upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H20. I was in conflict with others. ....	conflict	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

# WORRY

For each of the following, mark the answer which best describes how you feel.

		1 Strongly disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly agree
I1. I have general fears about cancer .....	cafear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I2. I am concerned about physical problems related to my cancer .....	caprob	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I3. I am worried about my appearance .....	appear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I4. I am worried about my cancer coming back .....	callback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I5. I mostly worry about my cancer and its treatment right before I go for a check-up .....	cachk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please respond to each question or statement by marking one box per row.  
In the past 7 days . . .

		1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
I6. I felt fearful .....	feltfear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I7. I found it hard to focus on anything other than my anxiety .....	focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I8. My worries overwhelmed me .....	worries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I9. I felt uneasy .....	uneasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I10. I felt nervous .....	feltnervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I11. I felt like I needed help for my anxiety .....	anxhelp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I12. I felt anxious .....	anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I13. I felt tense .....	felttense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I14. I felt worthless .....	worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I15. I felt helpless .....	helpless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I16. I felt depressed .....	depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I17. I felt hopeless .....	hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I18. I felt like a failure .....	failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I19. I felt unhappy .....	feltunhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I20. I felt I had nothing to look forward to .....	nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I21. I felt nothing could cheer me up .....	cheer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

J1. Do you currently have anxieties/fears as a result of your cancer or similar illness, or its treatment? **caanx**

- 1  No anxiety/fears                      4  A lot of anxiety/fears  
2  Small amount of anxiety/fears        5  Very many, extreme anxiety/fears  
3  Medium amount of anxiety/fears

J2. The next questions ask about problems you may have had after a very stressful experience. It could be something that happened to you directly, something you witnessed or something you learned happened to a close family member or close friend. Some examples include a serious accident, a death, or any event when you thought you (or someone close to you) might be hurt. Please answer a few questions about your most stressful event or the event that bothers you the most. In a few words or a phrase, please write down the event.

difev  
text

J3. How long ago did the event described above happen? (please estimate if you are not sure)

difevtm  
text

*Continue on next page.*

Keeping your most stressful event in mind, carefully read each problem below and mark one of the boxes on the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:

	1	2	3	4	5
	Not at all	A little bit	Moderately	Quite a bit	Extremely
K1. Repeated, disturbing, and unwanted memories of the stressful experience? . . . . . <b>ptsdmem</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K2. Repeated, disturbing dreams of the stressful experience? . . . . . <b>ptsddrm</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were <i>actually</i> back there <i>reliving</i> it)? . . . . . <b>ptsdagn</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K4. Feeling very upset when something reminded you of the stressful experience? . . . . . <b>ptsddups</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K5. Having strong physical reactions when something reminded you of the stressful experience ( <i>for example, heart pounding, trouble breathing, sweating</i> )? . . . . . <b>ptsdrem</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K6. Avoiding memories, thoughts, or feelings related to the stressful experience? . . . . . <b>ptsdavdm</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K7. Avoiding external reminders of the stressful experience ( <i>for example, people, places, conversations, activities, objects, or situations</i> )? . . . . . <b>ptsdavdr</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K8. Trouble remembering important parts of the stressful experience? . . . . . <b>ptsdtrem</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K9. Having strong negative beliefs about yourself, other people, or the world ( <i>for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous</i> )? . . . . . <b>ptsdnegb</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K10. Blaming yourself or someone else for the stressful experience or what happened after it? <b>ptsddbim</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K11. Having strong negative feelings such as fear, horror, anger, guilt, or shame? . . . . . <b>ptsdnegf</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K12. Loss of interest in activities you used to enjoy? . . . . . <b>ptsdlos</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K13. Feeling distant or cut off from other people? . . . . . <b>ptsddis</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K14. Trouble experiencing positive feelings ( <i>for example, being unable to feel happiness or have loving feelings for people close to you</i> )? . . . . . <b>ptsdpos</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K15. Irritable behavior, angry outbursts, or acting aggressively? . . . . . <b>ptsdirb</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K16. Taking too many risks or doing things that could cause you harm? . . . . . <b>ptsdrsk</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K17. Being "superalert" or watchful or on guard? . . . . . <b>ptsdalt</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K18. Feeling jumpy or easily startled? . . . . . <b>ptsdjmp</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K19. Having difficulty concentrating? . . . . . <b>ptsdcon</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K20. Trouble falling or staying asleep? . . . . . <b>ptsdslp</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

# CANCER IMPACT

Looking back over time since your cancer diagnosis, how much of an impact did your cancer experiences have on the following areas of your life overall?

Mark only one answer for each statement and try not to skip any items.

	5 Very positive impact	4 Somewhat positive impact	3 No impact	2 Somewhat negative impact	1 Very negative impact
L1. Your educational plans (classes completed, degrees earned, goals achieved, etc.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L2. Your work life or career (promotion, mobility, work environment, etc.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L3. Your diet . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L4. Your family plans (finding a partner, divorce, marriage, having children, etc.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L5. Your social life (friendships, social activities) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L6. Your living arrangements (moving in with relatives, selling a house, etc.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L7. Your financial situation . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L8. Your exercise activities . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L9. Your love life . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L10. Your religious beliefs (e.g., belief in a higher power) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L11. Your religious activities (e.g., affiliation with a religious institution, participation in religious activities) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L12. Other activities related to spirituality (e.g., meditation) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L13. Your retirement plans . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L14. Your ability to care or provide for your children . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L15. Your ability to be a caregiver to others (e.g., aging parents, sick spouse) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L16. Your ability to retain or to change your health care insurance . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L17. Your emotional or psychological needs . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L18. Other changes? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- L1. Your educational plans (classes completed, degrees earned, goals achieved, etc.) . . . . . caedc
- L2. Your work life or career (promotion, mobility, work environment, etc.) . . . . . cawrk
- L3. Your diet . . . . . cadiet
- L4. Your family plans (finding a partner, divorce, marriage, having children, etc.) . . . . . cafam
- L5. Your social life (friendships, social activities) . . . . . calif
- L6. Your living arrangements (moving in with relatives, selling a house, etc.) . . . . . calvg
- L7. Your financial situation . . . . . cafin
- L8. Your exercise activities . . . . . caexc
- L9. Your love life . . . . . calve
- L10. Your religious beliefs (e.g., belief in a higher power) . . . . . carelb
- L11. Your religious activities (e.g., affiliation with a religious institution, participation in religious activities) . . . . . carela
- L12. Other activities related to spirituality (e.g., meditation) . . . . . caspt
- L13. Your retirement plans . . . . . cart
- L14. Your ability to care or provide for your children . . . . . caprv
- L15. Your ability to be a caregiver to others (e.g., aging parents, sick spouse) . . . . . cacgv
- L16. Your ability to retain or to change your health care insurance . . . . . cains
- L17. Your emotional or psychological needs . . . . . caneed
- L18. Other changes? . . . . . caoth

**Specify.**

caspe

text

Please! Do not mark below this line

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by marking one box per row. Your answers should be what is true for you and not just what you think others want you to say. If the statement does not apply to you, mark N/A.

	0 Disagree Strongly	1 Disagree	2 Agree	3 Agree Strongly	4 N/A
M1. When all is said and done, I am the person who is responsible for taking care of my health . . . . . <b>hcresp</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M2. Taking an active role in my own health care is the most important thing that affects my health . . . . . <b>hcrole</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M3. I am confident I can help prevent or reduce problems associated with my health. . . . . <b>hcred</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M4. I know what each of my prescribed medications does . . . . . <b>hcrx</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M5. I am confident that I can tell whether I need to go to the doctor or whether I can take care of the health problem myself . . . . . <b>hcgodr</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M6. I am confident that I can tell a doctor concerns I have even when he or she does not ask . . . . . <b>hcconc</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M7. I am confident that I can follow through on medical treatments I may need to do at home . . . . . <b>hctrtr</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M8. I understand my health problems and what causes them . . . . . <b>hcundr</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M9. I know what treatments are available for my health problems . . . . . <b>hcopt</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M10. I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising. <b>hcmtn</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M11. I know how to prevent problems with my health. . . . . <b>hcpv</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M12. I am confident I can figure out solutions when new problems arise with my health . . . . . <b>hcsol</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M13. I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress . . . . . <b>hclife</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

These questions ask about your feelings and thoughts during the last month. For each item, please indicate with a mark how often you felt or thought a certain way.

	1 Never	2 Almost never	3 Sometimes	4 Fairly often	5 Very often
N1. In the last month, how often have you felt that you were unable to control the important things in your life? . . . . . <b>control</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N2. In the last month, how often have you felt confident about your ability to handle your personal problems? . . . . . <b>handle</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N3. In the last month, how often have you felt that things were going your way? . . . . . <b>going</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? . . . . . <b>piling</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

O. Below is a list of statements that describe problems people can have. We would like to know if you have had any of these problems over the past 6 months. Please complete all items. Please think about yourself as you read these statements and mark one response on each line.

	1 Never a problem	2 Sometimes a problem	3 Often a problem
1. I get upset easily. . . . .	prupst	<input type="checkbox"/>	<input type="checkbox"/>
2. It takes me longer to complete my work. . . . .	prwork1	<input type="checkbox"/>	<input type="checkbox"/>
3. I am disorganized. . . . .	prorg1	<input type="checkbox"/>	<input type="checkbox"/>
4. I forget instructions easily. . . . .	prfrgt1	<input type="checkbox"/>	<input type="checkbox"/>
5. I have problems completing my work. . . . .	prwork2	<input type="checkbox"/>	<input type="checkbox"/>
6. I have difficulty recalling things I had previously learned (e.g., names, places, events, activities). . . . .	prrc1	<input type="checkbox"/>	<input type="checkbox"/>
7. I get frustrated easily. . . . .	prfrt	<input type="checkbox"/>	<input type="checkbox"/>
8. My mood changes frequently. . . . .	prmmood	<input type="checkbox"/>	<input type="checkbox"/>
9. I have trouble finding things in my bedroom, closet or desk. . . . .	prfind	<input type="checkbox"/>	<input type="checkbox"/>
10. I forget what I am doing in the middle of things. . . . .	prfrgt2	<input type="checkbox"/>	<input type="checkbox"/>
11. I have problems getting started on my own. . . . .	prstrt	<input type="checkbox"/>	<input type="checkbox"/>
12. I am easily overwhelmed. . . . .	provwh	<input type="checkbox"/>	<input type="checkbox"/>
13. I have trouble doing more than one thing at a time. . . . .	prmlt	<input type="checkbox"/>	<input type="checkbox"/>
14. My desk/workspace is a mess. . . . .	prmess.1	<input type="checkbox"/>	<input type="checkbox"/>
15. I have trouble remembering things, even for a few minutes (such as directions, phone numbers, etc.). . . . .	prremb	<input type="checkbox"/>	<input type="checkbox"/>
16. I have trouble prioritizing my activities. . . . .	prpriort	<input type="checkbox"/>	<input type="checkbox"/>
17. I read slowly. . . . .	prread	<input type="checkbox"/>	<input type="checkbox"/>
18. I am slower than others when completing my work. . . . .	prwork3	<input type="checkbox"/>	<input type="checkbox"/>
19. I have trouble solving math problems in my head. . . . .	prmath	<input type="checkbox"/>	<input type="checkbox"/>
20. I don't work well under pressure. . . . .	prpres	<input type="checkbox"/>	<input type="checkbox"/>
21. I have trouble staying on the same topic when talking. . . . .	prtalk	<input type="checkbox"/>	<input type="checkbox"/>
22. I have a messy closet. . . . .	prmess2	<input type="checkbox"/>	<input type="checkbox"/>
23. People say I am easily distracted. . . . .	prdist	<input type="checkbox"/>	<input type="checkbox"/>
24. I have angry outbursts. . . . .	prang	<input type="checkbox"/>	<input type="checkbox"/>
25. I have a short attention span. . . . .	prattn	<input type="checkbox"/>	<input type="checkbox"/>
26. I overreact emotionally. . . . .	provreact1	<input type="checkbox"/>	<input type="checkbox"/>
27. I have trouble organizing work. . . . .	prorg2	<input type="checkbox"/>	<input type="checkbox"/>
28. I overreact to small problems. . . . .	provreact2	<input type="checkbox"/>	<input type="checkbox"/>
29. I have problems organizing activities. . . . .	prorg3	<input type="checkbox"/>	<input type="checkbox"/>
30. I have emotional outbursts for little reason. . . . .	proutb	<input type="checkbox"/>	<input type="checkbox"/>
31. I leave the bathroom a mess. . . . .	prmess3	<input type="checkbox"/>	<input type="checkbox"/>
32. I react more emotionally to situations than my friends. . . . .	premot	<input type="checkbox"/>	<input type="checkbox"/>
33. I leave my room or home a mess. . . . .	prmess4	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Sometimes" or "Often" to any of the questions in Section O, to what extent do the problems you may have checked interfere with your ability to function?

	1 Never	2 Sometimes	3 Often	4 Not applicable
1. In your home. . . . .	prhome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. At your job. . . . .	prjob	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In social situations. . . . .	prsocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In educational activities. . . . .	preduc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### OTHER ISSUES

Please rate how concerned you are about the following:

	1 Very concerned	2 Somewhat concerned	3 Concerned	4 Not very concerned	5 Not at all concerned
P1. Your future health . . . . .	confh1th	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P2. Your ability to have children . . . . .	conkids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P3. Developing another cancer . . . . .	conca	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P4. Your ability to get health insurance . . . . .	conhins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P5. Your ability to get life insurance . . . . .	conlins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P6. Your ability to cover expenses for health care . . . . .	conhcexp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P7. Your ability to cover expenses for prescribed medicine . . . . .	conrxexp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P8. Any other issues . . . . .	conoth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specify.

conspe  
text

Please! Do not mark below this line

Have you been diagnosed with any of the following medical problems?

**Q1. Depression** **depdx** 1  Yes 2  No

If yes, did you ever receive treatment? **deptrt**

1  Yes, in the past 2  Yes, currently 3  No

If yes, what type of treatment? (Mark all that apply) **ydeptrt**

Behavior/talk therapy/counseling **ydeptrt\_talk**

Hospitalization **ydeptrt\_hosp**

Medication **ydeptrt\_med**

List medications:

**depmed1-depmed7** coded

**Q2. Anxiety** **anxdx** 1  Yes 2  No

If yes, did you ever receive treatment? **anxtrt**

1  Yes, in the past 2  Yes, currently 3  No

If yes, what type of treatment? (Mark all that apply) **yanxtrt**

Behavior/talk therapy/counseling **yanxtrt\_talk**

Hospitalization **yanxtrt\_hosp**

Medication **yanxtrt\_med**

List medications:

**anxmed1-anxmed5** coded

**Q3. Attention Deficit Disorder (with or without hyperactivity)** 1  Yes 2  No **adddx**

If yes, did you ever receive treatment? **addtrt**

1  Yes, in the past 2  Yes, currently 3  No

If yes, what type of treatment? (Mark all that apply) **yaddtrt**

Behavior/talk therapy/counseling **yaddtrt\_talk**

Hospitalization **yaddtrt\_hosp**

Medication **yaddtrt\_med**

List medications:

**addmed1-addmed6** coded

**Q4. Bipolar Disorder** **biplrdx** 1  Yes 2  No

If yes, did you ever receive treatment? **biplrtrt**

1  Yes, in the past 2  Yes, currently 3  No

If yes, what type of treatment? (Mark all that apply) **ybiplrtrt**

Behavior/talk therapy/counseling **ybiplrtrt\_talk**

Hospitalization **ybiplrtrt\_hosp**

Medication **ybiplrtrt\_med**

List medications:

**biplrmed1-biplrmed5** coded

**Q5. Oppositional Defiant/Conduct Disorder** **odddx** 1  Yes 2  No

If yes, did you ever receive treatment? **oddrtr**

1  Yes, in the past 2  Yes, currently 3  No

If yes, what type of treatment? (Mark all that apply) **yoddrtr**

Behavior/talk therapy/counseling **yoddrtr\_talk**

Hospitalization **yoddrtr\_hosp**

Medication **yoddrtr\_med**

List medications:

**oddrmed1-oddrmed4** coded

**Q6. Schizophrenia/Paranoia** **schizdx** 1  Yes 2  No

If yes, did you ever receive treatment? **schiztrt**

1  Yes, in the past 2  Yes, currently 3  No

If yes, what type of treatment? (Mark all that apply) **yschiztrt**

Behavior/talk therapy/counseling **yschiztrt\_talk**

Hospitalization **yschiztrt\_hosp**

Medication **yschiztrt\_med**

List medications:

**schizmed1-schizmed4** coded

**Q7. Other psychiatric disorder (e.g. obsessive-compulsive disorder)** 1  Yes 2  No **opsydx**

If yes, please specify the disorder:

**psydxsp** coded

If yes, did you ever receive treatment? **opsytrt**

1  Yes, in the past 2  Yes, currently 3  No

If yes, what type of treatment? (Mark all that apply) **yopsytrt**

Behavior/talk therapy/counseling **yopsytrt\_talk**

Hospitalization **yopsytrt\_hosp**

Medication **yopsytrt\_med**

List medications:

**opsymed1-opsymed4** coded

Do any of these medical conditions prevent you from attending work (or school) or engaging in leisure activities on a regular basis (more days than not)? **psyint**

1  Yes 2  No

If yes, which condition(s):

**psyintsp1-psyintsp6** coded

Please! Do not mark below this line