



# COMMUNITY QUESTIONNAIRE

## Community Follow-Up

INTERVIEW/MAIL

CQ-CFU

Page 1 of 49

This questionnaire asks your opinion about how your spinal cord injury may be affecting you on a day-to-day basis.

This questionnaire has been written for a large group of people — all who have a spinal cord injury. Certain questions may not apply to your personal situation, but as every injury affects a person differently, all questions are included in this questionnaire. If you come across a question that you think does not apply to you, please answer it the best that you can.

### Sociodemographics Plus

Instructions: Ask the participant the following questions.

**1. What is your current relationship status?** (check ONE response only)

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Common Law
- ☐ Unknown

**2. What is your current body weight?**

Round up to  
the nearest  
whole number.

☐ lbs

☐ kg  
☐

**3. What is the highest level of formal education you have completed?** (check ONE response only)

- ☐ 8th Grade or less
- ☐ 9th through 11th Grade (includes completion of 9th, 10th or 11th Grade)
- ☐ High School Diploma or General Educational Development (GED) Diploma
- ☐ Associate Degree (includes community college degree or diploma [e.g. trade school], or CEGEP)
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate
- ☐ Other, Unclassified (specify): \_\_\_\_\_
- ☐ Unknown

**Sociodemographics Plus—continued**

**3. a) Currently, are you employed in a paid working setting?** (if you are currently employed but on long term disability, please choose 'Yes')

- ☐ Yes
- ☐ No (skip to question [45b](#) on page [32](#))

**b) Paid Work**

**b) If Yes, which one of the following best describes your paid work?** (check ONE response only)

- ☐ Working → **Full-time or part-time?**
- ☐ Full-time (includes persons who usually worked 30 hours or more per week, at their main or only job)
- ☐ Part-time (includes persons who usually worked less than 30 hours per week, at their main or only job)
- ☐ On-the-job training (paid)
- ☐ Sheltered workshop (e.g., paid work in a modified setting that may include increased supervision, physical assistance, modified tasks, etc.)
- ☐ On long-term disability

☐ ~~Unknown~~

**Sociodemographics Plus - continued**

**4. a) What is your paid occupation?**

- ☐ Executive, administrative and managerial (includes self-employment; e.g., managers, department heads, government officers, accountants, financial managers, personnel specialists etc.)
- ☐ Professional specialty (e.g., physician, lawyer, engineer, registered nurse, architect, computer systems analyst etc.)
- ☐ Technicians and related support (e.g., pilot, lab technician, dental hygienist, licensed practical nurse etc.)
- ☐ Sales
- ☐ Administrative support including clerical
- ☐ Private household (e.g., nanny, caregiver, house cleaner, gardener, caretaker etc.)
- ☐ Protective services (e.g., police, firefighter, security guard, etc.)
- ☐ Service, except protective and household (e.g., bartender, concierge, server, hospital orderly, janitor, cook, hair stylist etc.)
- ☐ Farming, forestry and fishing

- ☐ Precision, production, craft and repair (e.g., electrician, carpenter, mechanic, plumber, painter, machinist, baker etc.)
- ☐ Machine operators, assemblers, and inspectors (e.g., welder, typesetter, factory machine operator etc.)
- ☐ Transportation and material moving (e.g., truck driver, bus driver, train conductor, excavators, crane operator etc.)
- ☐ Handlers, equipment cleaners, helpers and labourers (e.g., construction labourer, garbage collector, store shelf-stocker, factory worker etc.)
- ☐ Military occupations
- ☐ Not applicable
- ☐ Unknown

### ~~Sociodemographics Plus - continued~~

#### Unpaid Work

**b) If ~~No~~, which one of the following best describes your unpaid work?** (check ONE response only. Does not include attendance to medical appointments or therapies)

- ☐ Homemaker
- ☐ On-the-job training (unpaid)
- ☐ Retired
- ☐ Student
- ☐ Unemployed
- ☐ Other (specify): \_\_\_\_\_ (e.g., volunteer work, etc.)
- ☐ Unknown

### ~~Sociodemographics Plus - continued~~

**5. a) Currently, what is your approximate total, annual household income?** (annual income of the WHOLE household BEFORE taxes, including subsidies, grants or other supplemental income from any source)

- ☐ Under 10,000
- ☐ 10,000 - 19,999
- ☐ 20,000 - 29,999
- ☐ 30,000 - 39,999
- ☐ 40,000 - 49,999
- ☐ 50,000 - 59,999
- ☐ 60,000 - 69,999
- ☐ 70,000 - 79,999

- ☐ 80,000 - 89,999
- ☐ 90,000 - 99,999
- ☐ 100,000 +
- ☐ Unknown

**b) How many people are in your household? \_\_\_\_\_**

**6. What, if any, compensation are you receiving as a result of your spinal cord injury?** (check ALL that apply)

- ☐ Worker's insurance (e.g., Worker's Compensation Board (WCB) or similar)
- ☐ Other disability insurance (e.g., Federal CPP Disability, Provincial Persons with Disability (PWD), private short or long term disability)
- ☐ Vehicle insurance (government or private)
- ☐ Other insurance (i.e., Employment Insurance, private insurance including payment protection plans, life insurance, accidental death and dismemberment, Veterans Benefits or Veterans Affairs Canada Benefits)
- ☐ Other compensation (specify): \_\_\_\_\_
- ☐ Unknown compensation type
- ☐ None



## Sociodemographics Plus - continued

**7. a) What type of setting do you currently live in:**

- ☐ Private residence (includes house, condominium, mobile home, apartment, or houseboat)
- ☐ Assisted living residence (semi-independent housing, a middle option between home support and residential care)
- ☐ Hotel/motel (includes short or long-term living arrangements, single room occupancy, etc.)
- ☐ Homeless (includes cave, car, tent, street, etc.)

**b) Indicate who you live with:** (choose ALL that apply)

- ☐ Partner/spouse
- ☐ Family member
- ☐ Non-family, unpaid (e.g., roommate)

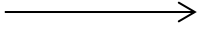
**c) Are you receiving health services at home?**

(e.g., homecare/support, home OT, etc.)

- ☐ Yes
- ☐ No

## INTERVIEW/MAIL

CQ-CFU  
Page 5 of 49

<input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Group living arrangement (includes transitional living facility or any residence shared by non-family members)	<input type="checkbox"/> Paid attendant <input type="checkbox"/> Alone <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> Nursing home/Long-term care within a hospital setting (includes skilled nursing facilities and institutions providing long-term, custodial, chronic disease care, and extended care) <input type="checkbox"/> Correctional institute (includes prison, penitentiary, jail, correctional centre, etc.)		<b>Skip to Question <u>98</u></b>

**8. a) What is your smoking /vaping (nicotine) history:** (Check ALL that apply; Note – this does not include marijuana use)

- ☐ Current smoker  
☐ Former smoker  
☐ Never smoked (skip to Question 9)  
☐ Current vaper  
☐ Former vaper  
☐ Never vaped (skip to Question 9)  
☐ Unknown (skip to Question 9)  
☐ ~~Current smoker~~  
☐ ~~Former smoker~~  
☐ ~~Never smoked (skip to Question 10)~~  
☐ ~~Unknown (skip to Question 10)~~

**b) If a former or current smoker/vaper, how many total years have you smoked or vaped? If a former or current smoker, for how many years did (have) you smoke(d)?** (please estimate if exact number unknown)

b)

\_\_\_\_\_ Years smoked  
☐ Unknown

\_\_\_\_\_ Years vaped  
☐ Unknown

\_\_\_\_\_ Years  
☐ Unknown

## Sociodemographics Plus - continued

**e) If a former or current smoker, on average how many (cigarettes/cigars/pipes) do (did) you smoke on a daily basis, on average how many (cigarettes/cigars/pipes) do (did) you smoke on a daily basis?**

[c\)](#) (Note: There are normally 20 cigarettes in a pack. Check ALL that apply. If less than one per day please enter 0)

- Cigarettes  
 Cigars  
 Pipe Bowls  
☐ Unknown

### ~~Sociodemographics Plus—continued~~

**9. a) How often do you have a drink containing alcohol?**

- ☐ Never (skip to Question [10+](#))  
☐ Monthly or less  
☐ 2-4 times/ month  
☐ 2-3 times/ week  
☐ 4 or more times/ week  
☐ Unknown

**b) How many alcoholic drinks do you have on a typical day when you are drinking?**

- ☐ 1 or 2  
☐ 3 or 4  
☐ 5 or 6  
☐ 7, 8, or 9  
☐ 10 or more  
☐ Unknown

**c) How often do you have six or more drinks on one occasion?**

- ☐ Never  
☐ Less than monthly  
☐ Monthly  
☐ Weekly  
☐ Daily or almost daily  
☐ Unknown  
☐

**10. Since your injury, have you used ~~pot~~cannabis/marijuana for MEDICAL reasons?**

(This includes use for any medical purpose even if not prescribed by a physician) (if this is your first community follow-up survey, please ~~only~~ consider the time since you were discharged from your initial inpatient hospital stay [acute care and/or rehab])

- ☐ Yes  
☐ No  
☐ Unknown

**10.11. a) ~~During the past year, have you used prescribed medications or street drugs for NON-MEDICAL/recreational reasons?~~ Since your injury, have you used prescribed medications, street drugs or ~~pot~~cannabis/marijuana for NON-MEDICAL reasons?** (if this is your first community follow-up survey, please ~~only~~ consider the time since you were discharged from your initial inpatient hospital stay [acute care and/or rehab])

- ☐ Yes
- ☐ No (skip to Pain Questionnaire)
- ☐ Unknown (skip to Pain Questionnaire)
- ☐

**b) If Yes, check ALL that apply:**

- ☐ Cocaine
- ☐ ~~Cannabis~~Pot/marijuana
- ☐ Hallucinogens
- ☐ Heroin/~~opiates~~
- ☐ ~~Opiates~~Speed/stimulants
- ☐ Speed/stimulants
- ☐ Medications prescribed for you
- ☐ Medications prescribed for someone else
- ☐ Other or unknown type

## Pain Questionnaire

**These questions ask your opinion about any pain you may be experiencing and how it may interfere with your daily living. Also, you will be asked to describe what you do to manage it.**

**10.1. a) Are you currently using or receiving any treatment for a pain problem?**

- ☐ Yes (e.g., medications, recreational drugs, physical therapies, etc.)
- ☐ No
- ☐ Unknown

**b) If Yes, What treatments do you use to manage your pain?** (check ALL that apply)

- ☐ Complementary (e.g., biofeedback, acupuncture, hypnosis)
- ☐ Medical and procedural or neuromodulation (e.g., nerve blocks, injections, implanted stimulators, intrathecal pump, TENS)
- ☐ Non-prescription medications (e.g., non prescription pain killers such as Tylenol®)
- ☐ Non-traditional (e.g., naturopathy, homeopathy, herbal remedies)
- ☐ Psychotherapeutic (e.g., psychotherapy, cognitive behavioural therapy, relaxation, stress management, psycho-education, support group)
- ☐ Physical therapies (e.g., physiotherapy, massage, chiropractic)
- ☐ Recreational drugs (e.g., marijuana)

- ☐ Prescription medications (e.g., morphine, codeine)
- ☐ Other (specify): \_\_\_\_\_
- ☐ Unknown

**11.2. Overall, how satisfied are you with the management of your pain?**

0 1 2 3 4 5 6 7 8 9 10 ☐ Unknown

Not at all satisfied Completely Satisfied

**12.3. a) Have you had any pain during the last 7 days, including today?**

- ☐ Yes
- ☐ No (skip to SCIM)

**b) If YES, in the LAST WEEK:****i. In general, how much has pain interfered with your day to day activities in the last week?**

0 1 2 3 4 5 6 7 8 9 10 ☐ Unknown

No interference Extreme interference

**ii. In general, how much has pain interfered with your overall mood in the past week?**

0 1 2 3 4 5 6 7 8 9 10 ☐ Unknown

No interference Extreme interference

**iii. In general, how much has pain interfered with your ability to get a good night's sleep?**

0 1 2 3 4 5 6 7 8 9 10 ☐ Unknown

No interference Extreme interference

**4.** (if this is your first community follow-up survey, please ~~only~~ consider the time since you were discharged from your initial inpatient hospital stay [acute care and/or rehab])

**a) In the past 12 months, have you experienced**

**Neuropathic pain?** (Pain, that is often ongoing and intense, caused by damage to nerves, that occurs spontaneously or by light touching and is characterized by feelings of burning, shooting, tingling, etc.)

- ☐ Yes
- ☐ No (skip to SCIM)
- ☐ Unknown (skip to SCIM)



Location(s) of your neuropathic pain: (check ALL that apply to your neuropathic pain)

- ☐ Head
- ☐ Neck and/or Shoulders
- ☐ Arms and/or Hands
- ☐ Torso (chest, abdomen, pelvis, and/or genitals)
- ☐ Back (upper and/or lower back)
- ☐ Hips, Buttocks, and/or Anus
- ☐ Upper Legs/Thighs
- ☐ Lower Legs or Feet

Average pain intensity of your neuropathic pain in the past week:



**b) You mentioned that you experienced this in the past 12 months. Have you received some form of treatment for the neuropathic pain?**

- ☐ Yes
- ☐ No

**c) When you had this, did it limit your activities?**

- ☐ Yes
- ☐ No

## SCIM – Spinal Cord Independence Measure (Version III, Self-report 2013)

### This section asks about functioning in activities of daily living.

For each item, please check the box next to the statement that best reflects **your current situation**. Please read the text carefully and only check one box in each section.

#### 1. Eating and drinking

- ☐ I need artificial feeding or a stomach tube
- ☐ I need total assistance with eating/drinking
- ☐ I need partial assistance with eating/drinking or for putting on/taking off adaptive devices
- ☐ I eat/drink independently, but I need adaptive devices or assistance for cutting food, pouring drinks or opening containers
- ☐ I eat/drink independently without assistance or adaptive devices

#### 2. (a) Washing your upper body and head

*Washing your **upper body and head** includes soaping and drying, and using a water tap.*

- ☐ I need total assistance
- ☐ I need partial assistance
- ☐ I am independent but need adaptive devices or specific equipment (e.g., bars, chair)
- ☒ I am independent and do not need adaptive devices or specific equipment

#### (b) Washing your lower body

*Washing your **lower body** includes soaping and drying, and using a water tap.*

- ☐ I need total assistance
- ☐ I need partial assistance
- ☐ I am independent but need adaptive devices or specific equipment (e.g., bars, chair)
- ☐ I am independent and do not need adaptive devices or specific equipment

#### 3. (a) Dressing your upper body

*Dressing the **upper body** includes putting on and taking off clothes like t-shirts, blouses, shirts, bras, shawls, or orthoses (e.g., arm splint, neck brace, corset)*

**Easy-to-dress** clothes are those **without** buttons, zippers, or laces

**Difficult-to-dress** clothes are those **with** buttons, zippers, or laces

- ☐ I need total assistance
- ☐ I need partial assistance, even with easy-to-dress clothes
- ☐ I do not need assistance with easy-to-dress clothes, but I need adaptive devices or specific equipment

- ☐ I am independent with easy-to-dress clothes and only need assistance or adaptive devices or a specific setting with difficult-to-dress clothes
- ☐ I am completely independent

#### **(b) Dressing your lower body**

*Dressing the **lower body** includes putting on and taking off clothes like shorts, trousers, shoes, socks, belts, or orthoses (e.g., leg splint)*

**Easy-to-dress** clothes are those **without** buttons, zippers, or laces

**Difficult-to-dress** clothes are those **with** buttons, zippers, or laces

- ☐ I need total assistance
- ☐ I need partial assistance, even with easy-to-dress clothes
- ☐ I do not need assistance with easy-to-dress clothes, but I need adaptive devices or specific equipment
- ☐ I am independent with easy-to-dress clothes and only need assistance or adaptive devices or a specific setting with difficult-to-dress clothes
- ☐ I am completely independent

#### **4. Grooming**

*Please think about activities such as washing hands and face, brushing teeth, combing hair, shaving, or applying makeup*

- ☐ I need total assistance
- ☐ I need partial assistance
- ☐ I am independent with adaptive devices
- ☐ I am independent without adaptive devices

#### **5. Breathing**

*Please check **only one box**, depending on whether or not you need a respiratory (tracheal) tube.*

*I **need** a respiratory (tracheal) tube...*

- ☐ as well as permanent or from time to time assisted ventilation
- ☐ as well as extra oxygen and a lot of assistance in coughing or respiratory tube management
- ☐ as well as little assistance in coughing or respiratory tube management

*I **do not** need a respiratory (tracheal) tube...*

- ☐ but I need extra oxygen or a lot of assistance in coughing or a mask (e.g., positive end-expiratory pressure (PEEP)) or assisted ventilation from time to time (e.g., bilevel positive airway pressure (BIPAP))
- ☐ and only little assistance or stimulation for coughing
- ☐ and can breathe and cough independently without any assistance or adaptive device

**6. Bladder management**

*Please think about the way you empty your bladder.*

**(a) Use of an indwelling catheter**

- ☐ Yes → Please go to question 7a
- ☐ No → Please also answer questions 6b and 6c

**(b) Intermittent catheterization**

- ☐ I need total assistance
- ☐ I do it myself with assistance (self-catheterization)
- ☐ I do it myself without assistance (self-catheterization)
- ☐ I do not use it

**(c) Use of external drainage instruments (e.g., condom catheter, diapers, sanitary napkins)**

- ☐ I need total assistance for using them
- ☐ I need partial assistance for using them
- ☐ I use them without assistance
- ☐ I am continent with urine and do not use external drainage instruments

**7. Bowel management****(a) Do you need assistance with bowel management (e.g., for applying suppositories)?**

- ☐ Yes
- ☐ No

**(b) My bowel movements are...**

- ☐ irregular or seldom (less than once in 3 days)
- ☐ regular (at least once every 3 days)

**(c) Faecal incontinence ('accidents') happens...**

- ☐ twice a month or more
- ☐ once a month
- ☒ not at all

**8. Using the toilet**

*Please think about the use of the toilet, cleaning your genital area and hands, putting on and taking off clothes, and the use of sanitary napkins or diapers.*

- ☐ I need total assistance
- ☐ I need partial assistance and cannot clean myself
- ☐ I need partial assistance but can clean myself
- ☐ I do not need assistance but I need adaptive devices (e.g., bars) or a special setting (e.g., wheelchair accessible toilet)
- ☐ I do not need any assistance, adaptive devices or a special setting

**9. How many of the following four activities can you perform without assistance or electrical aids**

- *turning your upper body in bed*
- *turning your lower body in bed*
- *sitting up in a bed*
- *doing push-ups in wheelchair (with or without adaptive devices)*

- ☐ none, I need assistance in all these activities
- ☐ one
- ☐ two or three
- ☐ all of them

**10. Transfers from the bed to the wheelchair**

- ☐ I need total assistance
- ☐ I need partial assistance, supervision or adaptive devices (e.g., sliding board)
- ☐ I do not need any assistance or adaptive devices
- ☐ I do not use a wheelchair

**11. Transfers from the wheelchair to the toilet/tub**

*Transferring also includes transfers from the wheelchair or bed to a toilet wheelchair*

- ☐ I need total assistance
- ☐ I need partial assistance, supervision or adaptive devices (e.g., grab-bars)
- ☐ I do not need any assistance or adaptive devices
- ☐ I do not use a wheelchair

**12. Moving around indoors**

Please check **only one box**, depending on whether or not you usually use a wheelchair or walk to move around indoors.

***I use a wheelchair. To move around, I...***

- ☐ need total assistance
- ☐ need an electric wheelchair or partial assistance to operate a manual wheelchair
- ☐ am independent in a manual wheelchair

***I walk indoors and I...***

- ☐ need supervision while walking (with or without walking aids)
- ☐ walk with a walking frame or crutches, swinging forward with both feet at a time
- ☐ walk with crutches or two canes, setting one foot before the other
- ☐ walk with one cane
- ☐ walk with a leg orthosis(es) only (e.g., leg splint)
- ☐ walk without walking aids

**13. Moving around moderate distances (10 to 100 metres)**

Please check **only one box**, depending on whether or not you usually use a wheelchair or walk to move around moderate distances (10 to 100 meters).

***I use a wheelchair. To move around, I...***

- ☐ need total assistance
- ☐ need an electric wheelchair or partial assistance to operate a manual wheelchair
- ☐ am independent in a manual wheelchair

***I walk moderate distances and I...***

- ☐ need supervision while walking (with or without walking aids)
- ☐ walk with a walking frame or crutches, swinging forward with both feet at a time
- ☐ walk with crutches or two canes, setting one foot before the other
- ☐ walk with one cane
- ☐ walk with a leg orthosis(es) only (e.g., leg splint)
- ☐ walk without walking aids

**14. Moving around outdoors for more than 100 metres**

Please check **only one box**, depending on whether or not you usually use a wheelchair or walk to move around outdoors for more than 100 metres.

***I use a wheelchair. To move around, I...***

- ☐ need total assistance
- ☐ need an electric wheelchair or partial assistance to operate a manual wheelchair
- ☐ am independent in a manual wheelchair

***I walk more than 100 metres and I...***

- ☐ need supervision while walking (with or without walking aids)
- ☐ walk with a walking frame or crutches, swinging forward with both feet at a time
- ☐ walk with crutches or two canes, setting one foot before the other
- ☐ walk with one cane
- ☐ walk with a leg orthosis(es) only (e.g., leg splint)
- ☐ walk without walking aids

**15. Going up and down stairs**

Please check **only one box**, depending on whether or not you are able to go up and down stairs.

- ☐ I am unable to go up and down stairs

***I can go up and down at least 3 steps...***

- ☐ but only with assistance or supervision
- ☐ but only with devices (e.g., handrail, crutch or cane)
- ☐ without any assistance, supervision or devices

**16. Transfers from the wheelchair into the car**

Transfers also include putting the wheelchair into and taking it out of the car.

- ☐ I need total assistance
- ☐ I need partial assistance, supervision or adaptive devices
- ☐ I do not need any assistance or adaptive devices
- ☐ I do not use a wheelchair

**17. Transfers from the floor to the wheelchair**

- ☐ I need assistance

☐ I do not need any assistance

☐ I do not use a wheelchair

## Secondary Complications & Health Conditions Questionnaire

If this is your first community follow-up survey, please ~~only~~ consider the time since you were discharged from your initial inpatient hospital stay (acute care and/or rehab). You can answer 'Yes' to questions below even if you have had the conditions for a long time.

<u>Secondary Complications &amp; Health Conditions</u>	<u>a) In the past 12 months, have you experienced this?</u> (If No or Don't know, skip to next Question)	<u>b) You mentioned that you experienced this in the past 12 months. Have you received some form of treatment for this problem?</u>	<u>c) When you had this, did it limit your activities?</u>
<u>1. Autonomic dysreflexia</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <del>(continue to Q2)</del> <input type="checkbox"/> Don't know <del>(continue to Q2)</del>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>2. Light headedness/dizziness</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>3. Respiratory infections</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>4. Pressure Ulcers - New</u>	<u>In the past 12 months (or if this is your first CFU, in the time since you were discharged from the hospital), how many NEW pressure ulcers have you had?</u> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 or more <input type="checkbox"/> None <input type="checkbox"/> Don't know  <u>Of these NEW pressure ulcers, how many are in a NEW location? (i.e., a location where you have not had a previous pressure ulcer)</u> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 or more	<input type="checkbox"/> Yes <input type="checkbox"/> No  <u>If Yes, were the new ulcers surgically treated?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



## INTERVIEW/MAIL

CQ-CFU

Page 17 of 49

<b><u>Secondary Complications &amp; Health Conditions</u></b>	<b><u>a) In the past 12 months, have you experienced this?</u></b> (If No or Don't know, skip to next Question)	<b><u>b) You mentioned that you experienced this in the past 12 months. Have you received some form of treatment for this problem?</u></b>	<b><u>c) When you had this, did it limit your activities?</u></b>
<b><u>5. Pressure Ulcers - Ongoing</u></b>	Other than the NEW pressure ulcers described above, how many ONGOING/UNRESOLVED pressure ulcers do you have that were previously existing? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 or more <input type="checkbox"/> None <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No  If Yes, were the ongoing or unresolved ulcers surgically treated? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><u>6. Urinary tract infections</u></b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><u>7. Urinary incontinence</u></b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><u>8. Fatigue</u></b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><u>9. Depression/Mood Problems</u></b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><u>10. Shoulder Problems</u></b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><u>11. Spasticity</u></b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know  Which best describes your muscle spasms  <input type="checkbox"/> Induced only by stimulation <input type="checkbox"/> Infrequent spontaneous spasms occurring < 1 per hour <input type="checkbox"/> Spontaneous spasms occurring < 10 per hour <input type="checkbox"/> Spontaneous spasms occurring > 10 per hour <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## INTERVIEW/MAIL

CQ-CFU

Page 18 of 49

<b>Secondary Complications &amp; Health Conditions</b>	<b>a) In the past 12 months, have you experienced this?</b> (If No or Don't know, skip to next Question)	<b>b) You mentioned that you experienced this in the past 12 months. Have you received some form of treatment for this problem?</b>	<b>c) When you had this, did it limit your activities?</b>
<u>12. Joint contractures</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>13. Bone fractures</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>14. Osteoarthritis/degenerative arthritis</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>15. Sexual dysfunction</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>16. Cerebrovascular disease, stroke, trans-ischemia attack (i.e. TIA)</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>17. Heart Disease</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>18. Diabetes</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No What type of treatment(s)? (check ALL that apply) <input type="checkbox"/> Diet modification <input type="checkbox"/> Medications taken by mouth <input type="checkbox"/> Insulin injections <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**1. ~~Neurological Deterioration~~** (~~Loss of muscle strength and/ or skin sensation, such as having less strength or losing all strength in an area, or having less feeling or losing all feeling in an area.~~)

a) ~~In the past 12 months, have you experienced neurological deterioration?~~ (check ONE)

☐ Once a year   
 ☐ Few times a year   
 ☐ Few times a month   
 ☐ Few times a week   
 ☐ Everyday   
 ☐ Never   
 ☐ Don't know   
 (if Never or Don't know, skip to Question 2)

b) ~~You mentioned that you experienced neurological deterioration in the past 12 months. Have you received some form of treatment for this problem?~~

☐ Yes    ☐ No

c) ~~When you had neurological deterioration, to what extent did it limit your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**2. Autonomic dysreflexia** (Sometimes called hyperreflexia—symptoms of dysreflexia include sudden rises in blood pressure and sweating, skin blotches, goose bumps, pupil dilation and headache. It can occur as the body's response to pain where an individual doesn't experience sensation, or from interference in the body's temperature-regulating systems.)

a) ~~In the past 12 months, have you experienced autonomic dysreflexia? (check ONE)~~

~~☐ Once a year   ☐ Few times a year   ☐ Few times a month   ☐ Few times a week   ☐ Everyday   ☐ Never   ☐ Don't know   (if Never or Don't know, skip to Question 3)~~

b) ~~You mentioned that you experienced autonomic dysreflexia in the past 12 months. Have you received some form of treatment for this problem?~~

~~☐ Yes   ☐ No~~

c) ~~When you had autonomic dysreflexia, to what extent did it limit your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**3. Light headedness/dizziness** (Sometimes called postural hypotension—This involves a strong sensation of light headedness following a change in position. It is caused by a sudden drop in blood pressure.)

a) ~~In the past 12 months, have you experienced light headedness/dizziness? (check ONE)~~

~~☐ Once a year   ☐ Few times a year   ☐ Few times a month   ☐ Few times a week   ☐ Everyday   ☐ Never   ☐ Don't know   (if Never or Don't know, skip to Question 4)~~

b) ~~You mentioned that you experienced light headedness/dizziness in the past 12 months. Have you received some form of treatment for this problem?~~

~~☐ Yes   ☐ No~~

c) ~~When you had light headedness/dizziness, to what extent did it limit your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**4. High Blood Pressure** (High blood pressure—Ongoing blood pressure readings that are higher than 140/90mmHg [normal is 120/80mmHg.])

a) ~~In the past 12 months, have you had high blood pressure? (check ONE)~~

~~☐ Yes   ☐ No   ☐ Don't know   (if No or Don't know, skip to Question 5)~~

b) ~~You mentioned that you had high blood pressure in the past 12 months. Have you received some form of treatment for this problem? (check ONE)~~

~~☐ Yes   ☐ No~~

~~c) How much has high blood pressure limited your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

~~**5. Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE)** (DVT = blood in the veins of the legs or arms that collects and forms into a thick mass (i.e. blood clot); PE = a piece of a blood clot that breaks free, lodges in the lung, and may cause breathing difficulty.)~~

~~a) In the past 12 months, have you experienced DVT/PE? (check ONE)~~

~~☐ Once a year   ☐ Few times a year   ☐ Few times a month   ☐ Few times a week   ☐ Everyday   ☐ Never   ☐ Don't know   (if Never or Don't know, skip to Question 6)~~

~~b) You mentioned that you experienced DVT/PE in the past 12 months. Have you received some form of treatment for this problem?~~

~~☐ Yes   ☐ No~~

~~c) When you had DVT/PE, to what extent did it limit your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

~~**6. Respiratory infections** (Also called pneumonia—Short term lung disease caused by infection that includes inflammation and congestion; followed by clearing. It includes increased secretions, fever, chills, coughing, and difficulty breathing.)~~

~~a) In the past 12 months, have you experienced respiratory infection(s)? (check ONE)~~

~~☐ Once a year   ☐ Few times a year   ☐ Few times a month   ☐ Few times a week   ☐ Everyday   ☐ Never   ☐ Don't know   (if Never or Don't know, skip to Question 7)~~

~~b) You mentioned that you experienced respiratory infection(s) in the past 12 months. Have you received some form of treatment for this problem?~~

~~☐ Yes   ☐ No~~

~~c) When you had respiratory infection(s), to what extent did it limit your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

~~**7. Asthma** (A chronic (long term) lung disease that inflames and narrows the airways. Asthma causes recurring periods of wheezing (a whistling sound when you breathe), chest tightness, shortness of breath, and coughing. The coughing often occurs at night or early in the morning.)~~

~~a) In the past 12 months, have you had asthma? (check ONE)~~

~~☐ Yes   ☐ No   ☐ Don't know   (if No or Don't know, skip to Question 8)~~

~~b) You mentioned that you had asthma in the past 12 months. Have you received some form of treatment for this problem? (check ONE)~~

~~☐ Yes   ☐ No~~

~~c) How much has asthma limited your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**~~8. Chronic Lung Disease~~** (Chronic Obstructive Pulmonary Disease, emphysema, chronic bronchitis, tuberculosis, etc.)

~~a) In the past 12 months, have you had a chronic lung disease? (check ONE)~~

~~☐ Yes   ☐ No   ☐ Don't know   (if No or Don't know, skip to Question 9)~~

~~b) You mentioned that you had chronic lung disease in the past 12 months. Have you received some form of treatment for this problem? (check ONE)~~

~~☐ Yes   ☐ No   (if No, skip to Question 8d)~~

~~c) Do you take any medicines for your emphysema, chronic bronchitis, or COPD?~~

~~☐ Yes   ☐ No~~

~~d) How much has the chronic lung disease limited your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**~~9. Pressure Ulcers – New~~** (Also called skin ulcers, bedsores, and decubitus ulcers – A skin wound often caused by constant pressure against the skin causing reduced blood supply to the area and death of the tissue. These develop as a skin rash or redness and may progress to an infected sore.)

~~a) In the past 12 months (or if this is your first CFU, in the time since you were discharged from the hospital), how many NEW pressure ulcers have you had? (check ONE)~~

~~☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5 or more   ☐ None   ☐ Don't know   (if None or Don't Know, skip to Question 10)~~

~~b) Of these NEW pressure ulcers, how many are in a NEW location? (i.e., a location where you have not had a previous pressure ulcer)~~

~~☐ 0   ☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5 or more~~

~~c) You mentioned that you experienced new pressure ulcers in the past 12 months. Have you received some form of treatment for this problem?~~

~~☐ Yes   ☐ No   (if No, skip to Question 9c)~~

~~d) If yes, were the new ulcers surgically treated?~~

~~☐ Yes   ☐ No~~

~~e) When you had new pressure ulcers, to what extent did it limit your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**~~10. Pressure Ulcers—Ongoing~~** (Also called skin ulcers, bedsores, and decubitus ulcers—A skin wound often caused by constant pressure against the skin causing reduced blood supply to the area and death of the tissue. These develop as a skin rash or redness and may progress to an infected sore.)

a) ~~Other than the NEW pressure ulcers described above, how many ONGOING/UNRESOLVED pressure ulcers do you have that were previously existing? (check ONE)~~

~~— ☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5 or more   ☐ None   ☐ Don't know~~

~~(if None or Don't know, skip to Question 11)~~

b) ~~You mentioned that you have ongoing or unresolved pressure ulcers. Have you received some form of treatment for this problem?~~

~~☐ Yes   ☐ No   (if No, skip to Question 10d)~~

c) ~~If yes, were the ongoing or unresolved ulcers surgically treated?~~

~~☐ Yes   ☐ No~~

d) ~~When you had ongoing or unresolved pressure ulcers, to what extent did it limit your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**~~11. Urinary tract infections~~** (This includes infections such as cystitis and pseudomonas. Symptoms include pain when urinating, a burning sensation throughout the body, blood in the urine and cloudy urine.)

a) ~~In the past 12 months, have you experienced urinary tract infection(s)? (check ONE)~~

~~☐ Once a year   ☐ Few times a year   ☐ Few times a month   ☐ Few times a week   ☐ Everyday   ☐ Never   ☐ Don't know   (if Never or Don't know, skip to Question 12)~~

b) ~~You mentioned that you experienced urinary tract infection(s) in the past 12 months. Have you received some form of treatment for this problem?~~

~~☐ Yes   ☐ No~~

c) ~~When you had urinary tract infection(s), to what extent did it limit your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**~~12. Kidney or bladder stones~~** (Small stones blocking the urinary system.)

a) ~~In the past 12 months, have you experienced kidney or bladder stones? (check ONE)~~

~~☐ Once a year   ☐ Few times a year   ☐ Few times a month   ☐ Few times a week   ☐ Everyday   ☐ Never   ☐ Don't know   (if Never or Don't know, skip to Question 13)~~

b) ~~You mentioned that you experienced kidney or bladder stones in the past 12 months. Have you received some form of treatment for this problem?~~

~~☐ Yes   ☐ No~~

c) ~~When you had kidney or bladder stones, to what extent did it limit your activities? (check ONE)~~

☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely

**13. Urinary incontinence** (Urine leakage, catheter bypassing.)

a) In the past 12 months, have you experienced urinary incontinence? (check ONE)

☐ Once a year   ☐ Few times a year   ☐ Few times a month   ☐ Few times a week   ☐ Everyday   ☐ Never   ☐ Don't know   (if Never or Don't know, skip to Question 14)

b) You mentioned that you experienced urinary incontinence in the past 12 months. Have you received some form of treatment for this problem?

☐ Yes   ☐ No

c) When you had urinary incontinence, to what extent did it limit your activities? (check ONE)

☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely

**14. Kidney disease** (An umbrella term for a variety of diseases affecting the kidneys including: kidney failure, infection or nephritis.)

a) In the past 12 months, have you had kidney disease? (check ONE)

☐ Yes   ☐ No   ☐ Don't know   (if No or Don't know, skip to Question 15)

b) You mentioned that you had kidney disease in the past 12 months. Have you received some form of treatment for this problem? (check ONE)

☐ Yes   ☐ No

c) How much has kidney disease limited your activities? (check ONE)

☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely

**15. Bowel incontinence** (Bowel leakage.)

a) In the past 12 months, have you experienced bowel incontinence? (check ONE)

☐ Once a year   ☐ Few times a year   ☐ Few times a month   ☐ Few times a week   ☐ Everyday   ☐ Never   ☐ Don't know   (if Never or Don't know, skip to Question 16)

b) You mentioned that you experienced bowel incontinence in the past 12 months. Have you received some form of treatment for this problem?

☐ Yes   ☐ No

c) When you had bowel incontinence, to what extent did it limit your activities? (check ONE)

☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely

**16. Constipation** (Hard stool that is difficult to pass, or fewer bowel movements per week than is normal for you.)

~~a) In the past 12 months, have you experienced constipation? (check ONE)~~

~~☐ Once a year   ☐ Few times a year   ☐ Few times a month   ☐ Few times a week   ☐ Everyday   ☐ Never   ☐ Don't know   (if Never or Don't know, skip to Question 17)~~

~~b) You mentioned that you experienced constipation in the past 12 months. Have you received some form of treatment for this problem?~~

~~☐ Yes   ☐ No~~

~~c) When you had constipation, to what extent did it limit your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**~~17. Fatigue~~** (Constantly feeling tired, having low energy, feeling listless.)

~~a) In the past 12 months, have you experienced fatigue? (check ONE)~~

~~☐ Once a year   ☐ Few times a year   ☐ Few times a month   ☐ Few times a week   ☐ Everyday   ☐ Never   ☐ Don't know   (if Never or Don't know, skip to Question 18)~~

~~b) You mentioned that you experienced fatigue in the past 12 months. Have you received some form of treatment for this problem?~~

~~☐ Yes   ☐ No~~

~~c) When you had fatigue, to what extent did it limit your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**~~18. Sleep Apnea~~** (A common disorder in which you have one or more pauses in breathing or shallow breaths while you sleep. The most common type of sleep apnea is obstructive sleep apnea. In this condition, the airway collapses or becomes blocked during sleep. This causes shallow breathing or breathing pauses.)

~~a) In the past 12 months, have you had sleep apnea? (check ONE)~~

~~☐ Yes   ☐ No   ☐ Don't know   (if No or Don't know, skip to Question 19)~~

~~b) You mentioned that you had sleep apnea in the past 12 months. Have you received some form of treatment for this problem? (check ONE)~~

~~☐ Yes   ☐ No~~

~~c) How much has sleep apnea limited your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**~~19. Trouble sleeping~~** (Difficulty falling asleep, waking during the night, pauses in breathing during sleep, etc.)

~~a) In the past 12 months, have you experienced trouble sleeping? (check ONE)~~

~~☐   ☐   ☐   ☐   ☐ Everyday   ☐ Never   (if Never or Don't know,~~



Once a year    Few times a year    Few times a month    Few times a week    Don't know    skip to Question 20)

b) ~~You mentioned that you experienced trouble sleeping in the past 12 months. Have you received some form of treatment for this problem?~~

☐ ~~Yes~~    ☐ ~~No~~

c) ~~When you had trouble sleeping, to what extent did it limit your activities? (check ONE)~~

☐ ~~Not at all~~    ☐ ~~Very little~~    ☐ ~~To some extent~~    ☐ ~~To a great extent~~    ☐ ~~Completely~~

**20. Depression/Mood Problems** (A state of intense sadness that **lasts for more than two weeks**, and has advanced to the point of interfering with daily life—feeling “down”, being tired, or feeling irritable for no apparent reason.)

a) ~~In the past 12 months, have experienced depression/mood problems? (check ONE)~~

☐ ~~A little of the time~~    ☐ ~~Some of the time~~    ☐ ~~Most of the time~~    ☐ ~~All of the time~~    ☐ ~~Don't know~~    ☐ ~~None of the time~~    (if Don't know or None of the time, skip to Question 21)

b) ~~You mentioned that you experienced depression/mood problems in the past 12 months. Have you received some form of treatment for this problem? (check ONE)~~

☐ ~~Yes~~    ☐ ~~No~~

c) ~~How much has depression/mood problems limited your activities? (check ONE)~~

☐ ~~Not at all~~    ☐ ~~Very little~~    ☐ ~~To some extent~~    ☐ ~~To a great extent~~    ☐ ~~Completely~~

**21. Dementia** (Alzheimer's disease or another form of dementia)

a) ~~In the past 12 months, have experienced dementia? (check ONE)~~

☐ ~~Yes~~    ☐ ~~No~~    ☐ ~~Don't know~~    (if No or Don't know, skip to Question 22)

b) ~~You mentioned that you experienced dementia in the past 12 months. Have you received some form of treatment for this problem? (check ONE)~~

☐ ~~Yes~~    ☐ ~~No~~

c) ~~How much has dementia limited your activities? (check ONE)~~

☐ ~~Not at all~~    ☐ ~~Very little~~    ☐ ~~To some extent~~    ☐ ~~To a great extent~~    ☐ ~~Completely~~

**22. ~~Shoulder problems~~** (This includes pain in the shoulder joints and/ or muscles. People who must overuse a particular muscle group, such as shoulder muscles, or who put too much strain on their joints are at risk of developing pain.)

a) ~~In the past 12 months, have you experienced shoulder problems? (check ONE)~~

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(if Never or Don't know, skip to Question 23)
Once a year	Few times a year	Few times a month	Few times a week	Everyday	Never	Don't know	

b) ~~You mentioned that you experienced shoulder problems in the past 12 months. Have you received some form of treatment for this problem?~~

☐ ~~Yes~~   ☐ ~~No~~

c) ~~When you had shoulder problems, to what extent did it limit your activities? (check ONE)~~

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Not at all	Very little	To some extent	To a great extent	Completely	

**23. ~~Elbow/ Wrist problems~~** (This includes pain in the elbow and/ or wrist joints and muscles. People who must overuse a particular muscle group, such as elbows or wrists, or who put too much strain on their joints are at risk of developing pain.)

a) ~~In the past 12 months, have you experienced elbow/wrist problems? (check ONE)~~

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(if Never or Don't know, skip to Question 24)
Once a year	Few times a year	Few times a month	Few times a week	Everyday	Never	Don't know	

b) ~~You mentioned that you experienced elbow/wrist problems in the past 12 months. Have you received some form of treatment for this problem?~~

☐ ~~Yes~~   ☐ ~~No~~

c) ~~When you had elbow/wrist problems, to what extent did it limit your activities? (check ONE)~~

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Not at all	Very little	To some extent	To a great extent	Completely	

**24. ~~Neuropathic pain~~** (Pain, that is often ongoing and intense, caused by damage to nerves, that occurs spontaneously or by light touching and is characterized by feelings of burning, shooting, tingling, etc.)

a) ~~In the past 12 months, have you experienced neuropathic pain? (check ONE)~~

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(if Never or Don't know, skip to Question 25)
Once a year	Few times a year	Few times a month	Few times a week	Everyday	Never	Don't know	

b) ~~Location(s) of your neuropathic pain: (check ALL that apply to your neuropathic 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"/>
Head						Upper Legs/Thighs	Lower

Neck  
and/or  
ShouldersArms  
and/or  
HandsTorso (chest,  
abdomen, pelvis,  
and/or genitals)Back (upper  
and/or lower  
back)Hips,  
Buttocks,  
and/or AnusLeg  
s or  
Feet~~c) Average pain intensity of your neuropathic pain in the past week:~~~~No  
pain~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~Pain as  
bad as  
you can  
imagine~~~~☐  
Don't  
know~~~~d) Have you received some form of treatment for the neuropathic pain?~~~~☐ Yes~~~~☐ No~~~~☐ Don't know~~~~e) When you had neuropathic pain, to what extent did it limit your activities? (check ONE)~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~Not at all~~~~Very little~~~~To some extent~~~~To a great extent~~~~Completely~~~~Don't  
know~~**25. Spasticity** (Spontaneous and uncontrolled, jerky muscle movements, such as uncontrolled muscle twitch or spasm. Often spasticity increases with infection or some kind of restriction, like a tight shoe or belt.)~~a) In the past 12 months, have you ever had muscle spasms? (check ONE)~~~~☐ Yes~~~~☐ No~~~~☐ Don't know~~~~(if No or Don't know, skip to Question 26)~~~~b) Which best describes your muscle spasms~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~Induced only  
by stimulation~~~~Infrequent spontaneous  
spasms occurring < 1  
per hour~~~~Spontaneous spasms  
occurring < 10 per hour~~~~Spontaneous spasms  
occurring > 10 per  
hour~~~~Don't  
know~~~~c) Have you received some form of treatment for the muscle spasms?~~~~☐ Yes~~~~☐ No~~~~d) When you had muscle spasms, to what extent did they limit your activities? (check ONE)~~~~☐ Not at all~~~~☐ Very little~~~~☐ To some extent~~~~☐ To a great extent~~~~☐  
Completely~~**26. Joint contractures** (Limitation in range of motion caused by a shortening of the soft tissue around a joint, such as an elbow or hip. This occurs when a joint cannot move frequently enough through its range of motion. Pain often accompanies this problem.)~~a) In the past 12 months, have you experienced joint contractures? (check ONE)~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~☐~~~~Everyday~~~~Never~~~~(if Never  
or Don't  
know, skip~~

Once a year      Few times a year      Few times a month      Few times a week      Don't know      to Question 27)

~~b) You mentioned that you experienced joint contractures in the past 12 months. Have you received some form of treatment for this problem?~~

~~☐ Yes    ☐ No~~

~~c) When you had joint contractures, to what extent did it limit your activities? (check ONE)~~

~~☐ Not at all    ☐ Very little    ☐ To some extent    ☐ To a great extent    ☐ Completely~~

**27. Osteoporosis** (Changes in bone density causing loss of bone and higher risk of breaking bones.)

~~a) In the past 12 months, have you had osteoporosis? (check ONE)~~

~~☐ Yes    ☐ No    ☐ Don't know    (if No or Don't know, skip to Question 28)~~

~~b) You mentioned that you had osteoporosis in the past 12 months. Have you received some form of treatment for this problem? (check ONE)~~

~~☐ Yes    ☐ No~~

~~c) How much has osteoporosis limited your activities? (check ONE)~~

~~☐ Not at all    ☐ Very little    ☐ To some extent    ☐ To a great extent    ☐ Completely~~

**28. Bone fractures** (Broken bones.)

~~a) In the past 12 months, have you had bone fractures? (check ONE)~~

~~☐ Yes    ☐ No    ☐ Don't know    (if No or Don't know, skip to Question 29)~~

~~b) You mentioned that you had bone fractures in the past 12 months. Have you received some form of treatment for this problem? (check ONE)~~

~~☐ Yes    ☐ No~~

~~c) How much have the bone fractures limited your activities? (check ONE)~~

~~☐ Not at all    ☐ Very little    ☐ To some extent    ☐ To a great extent    ☐ Completely~~

**29. Osteoarthritis/degenerative arthritis** ("Wear and tear" on joints causing pain, swelling, and reduced movement/function of the joint.)

~~a) In the past 12 months, have you had osteoarthritis/degenerative arthritis? (check ONE)~~

~~☐ Yes    ☐ No    ☐ Don't know    (if No or Don't know, skip to Question 30)~~

~~b) You mentioned that you had osteoarthritis/degenerative arthritis in the past 12 months. Have you received some form of treatment for this problem? (check ONE)~~

~~☐ Yes   ☐ No~~~~c) How much has osteoarthritis/degenerative arthritis limited your activities? (check ONE)~~~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~~~**30. Rheumatoid Arthritis** (A form of arthritis that causes pain, swelling, stiffness and loss of function in your joints. It can affect any joint but is common in the wrist and fingers.)~~~~a) In the past 12 months, have you had rheumatoid arthritis? (check ONE)~~~~☐ Yes   ☐ No   ☐ Don't know   (if No or Don't know, skip to Question 31)~~~~b) You mentioned that you had rheumatoid arthritis in the past 12 months. Have you received some form of treatment for this problem? (check ONE)~~~~☐ Yes   ☐ No~~~~c) How much has rheumatoid arthritis limited your activities? (check ONE)~~~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~~~**31. Sexual dysfunction** (This includes dissatisfaction with sexual functioning. Causes for dissatisfaction can be decreased sensation, changes in body image, difficulty in movement, and problems with bowel or bladder, like infections.)~~~~a) In the past 12 months, have you experienced sexual dysfunction? (check ONE)~~~~☐ Once a year   ☐ Few times a year   ☐ Few times a month   ☐ Few times a week   ☐ Everyday   ☐ Never   ☐ Don't know   (if Never or Don't know, skip to Question 32)~~~~b) You mentioned that you experienced sexual dysfunction in the past 12 months. Have you received some form of treatment for this problem?~~~~☐ Yes   ☐ No~~~~c) When you had sexual dysfunction, to what extent did it limit your activities? (check ONE)~~~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~~~**32. Cerebrovascular disease, stroke, trans-ischemia attack (i.e. TIA)** (Permanent or temporary loss or reduction of brain function due to an interruption of blood flow to the brain.)~~~~a) In the past 12 months, have you had a cerebrovascular accident? (check ONE)~~~~☐ Yes   ☐ No   ☐ Don't know   (if No or Don't know, skip to Question 33)~~~~b) You mentioned that you had a cerebrovascular accident in the past 12 months. Have you received some form of treatment for this problem? (check ONE)~~

☐ Yes ☐ No

c) How much has the cerebrovascular accident limited your activities? (check ONE)

☐ Not at all ☐ Very little ☐ To some extent ☐ To a great extent ☐ Completely

**33. Heart Disease** (An umbrella term for a variety of diseases affecting the heart including: heart attack, angina [i.e. chest pain], heart failure, coronary artery disease.)

a) In the past 12 months, have you had heart disease? (check ONE)

☐ Yes ☐ No ☐ Don't know (if No or Don't know, skip to Question 34)

b) You mentioned that you had heart disease in the past 12 months. Have you received some form of treatment for this problem? (check ONE)

☐ Yes ☐ No

c) How much has heart disease limited your activities? (check ONE)

☐ Not at all ☐ Very little ☐ To some extent ☐ To a great extent ☐ Completely

**34. Liver disease** (An umbrella term for a variety of diseases affecting the liver including: cirrhosis or hepatitis.)

a) In the past 12 months, have you had liver disease? (check ONE)

☐ Yes ☐ No ☐ Don't know (if No or Don't know, skip to Question 35)

b) You mentioned that you had liver disease in the past 12 months. Have you received some form of treatment for this problem? (check ONE)

☐ Yes ☐ No

c) How much has asthma limited your activities? (check ONE)

☐ Not at all ☐ Very little ☐ To some extent ☐ To a great extent ☐ Completely

**35. Weight problems** (Difficulty keeping body weight [specifically the ratio of muscle to fat mass] at a healthy level and/or issues with size of abdomen.)

a) In the past 12 months, have you experienced weight problems? (check ONE)

☐ Once a year ☐ Few times a year ☐ Few times a month ☐ Few times a week ☐ Everyday ☐ Never ☐ Don't know (if Never or Don't know, skip to Question 36)

b) You mentioned that you experienced weight problems in the past 12 months. Have you received some form of treatment for this problem?

☐ Yes ☐ No

~~c) When you had weight problems, to what extent did it limit your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**36. Diabetes** (Diabetes is a problem resulting from irregularities in blood sugar levels. Symptoms include frequent urination and excessive thirst. This condition is diagnosed by a physician.)

~~a) In the past 12 months, have you had diabetes? (check ONE)~~

~~☐ Yes   ☐ No   ☐ Don't know   (if No or Don't know, skip to Question 37)~~

~~b) You mentioned that you had diabetes in the past 12 months. Have you received some form of treatment for this problem? (check ONE)~~

~~☐ Yes   ☐ No   (if No, skip to Question 36d)~~

~~c) What type of treatment(s)? (check ALL that apply)~~

~~☐ Diet modification   ☐ Medications taken by mouth   ☐ Insulin injections   ☐ Other (specify): \_\_\_\_\_~~

~~d) How much has the diabetes limited your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**37. Cancer** (Uncontrolled growth and spread of abnormal cells in some part of the body.)

~~a) In the past 12 months, have you had cancer? (check ONE)~~

~~☐ Yes   ☐ No   ☐ Don't know   (if No or Don't know, skip to Question 38)~~

~~b) Has the cancer spread or metastasized to other parts of your body?~~

~~☐ Yes   ☐ No~~

~~c) You mentioned that you experienced cancer in the past 12 months. Have you received some form of treatment for this problem?~~

~~☐ Yes   ☐ No~~

~~d) How much has cancer limited your activities? (check ONE)~~

~~☐ Not at all   ☐ Very little   ☐ To some extent   ☐ To a great extent   ☐ Completely~~

**38. Ulcer or Gastric Esophageal Reflux Disease** (Sores in the lining of the stomach or intestines, or regurgitation of the contents of the stomach into the esophagus causing feelings of heartburn.)

~~a) In the past 12 months, have you had ulcer(s) or gastric esophageal reflux disease? (check ONE)~~

~~☐ Yes   ☐ No   ☐ Don't know   (if No or Don't know, skip to Question 39)~~

b) You mentioned that you had ulcer(s) or gastric esophageal reflux disease in the past 12 months. Have you received some form of treatment for this problem? (check ONE)

☐ Yes ☐ No

c) How much has the ulcer(s) or gastric esophageal reflux disease limited your activities? (check ONE)

☐ Not at all ☐ Very little ☐ To some extent ☐ To a great extent ☐ Completely

**39. Injuries caused by loss of sensation** (Injury may occur because of a lack of sensation, such as burns from carrying hot liquids in the lap or sitting too close to a heater or fire.)

a) In the past 12 months, have you experienced injuries caused by loss of sensation? (check ONE)

☐ Once a year ☐ Few times a year ☐ Few times a month ☐ Few times a week ☐ Everyday ☐ Never ☐ Don't know (if Never or Don't know, skip to Question 40)

b) You mentioned that you experienced injuries caused by loss of sensation in the past 12 months. Have you received some form of treatment for this problem?

☐ Yes ☐ No

c) When you had injuries caused by loss of sensation, to what extent did it limit your activities? (check ONE)

☐ Not at all ☐ Very little ☐ To some extent ☐ To a great extent ☐ Completely

**40. Other Health Condition (specify):** \_\_\_\_\_

a) In the past 12 months, have you had this condition? (check ONE)

☐ Yes ☐ No ☐ Don't know (if No or Don't know, proceed to Health Care Utilisation Measure)

b) You mentioned that you had this condition in the past 12 months. Have you received some form of treatment for this problem? (check ONE)

☐ Yes ☐ No

c) How much has this condition limited your activities? (check ONE)

☐ Not at all ☐ Very little ☐ To some extent ☐ To a great extent ☐ Completely

**1. Autonomic dysreflexia** (Sometimes called hyperreflexia - symptoms of dysreflexia include sudden rises in blood pressure and sweating, skin blotches, goose bumps, pupil dilation and headache. It can occur as the body's response to pain where an individual doesn't experience sensation, or from interference in the body's temperature regulating systems.)

**2. Light headedness/dizziness** (Sometimes called postural hypotension - This involves a strong sensation of light-headedness following a change in position. It is caused by a sudden drop in blood pressure.)

**3. Respiratory infections** (Also called pneumonia - Short-term lung disease caused by infection that includes inflammation and congestion; followed by clearing. It includes increased secretions, fever, chills, coughing, and difficulty breathing.)



- 4. Pressure Ulcers - New** (Also called skin ulcers, bedsores, and decubitus ulcers - A skin wound often caused by constant pressure against the skin causing reduced blood supply to the area and death of the tissue. These develop as a skin rash or redness and may progress to an infected sore.)
- 5. Pressure Ulcers - Ongoing** (Also called skin ulcers, bedsores, and decubitus ulcers - A skin wound often caused by constant pressure against the skin causing reduced blood supply to the area and death of the tissue. These develop as a skin rash or redness and may progress to an infected sore.)
- 6. Urinary tract infections** (This includes infections such as cystitis and pseudomonas. Symptoms include pain when urinating, a burning sensation throughout the body, blood in the urine and cloudy urine.)
- 7. Urinary incontinence** (Urine leakage, catheter bypassing.)
- 8. Fatigue** (Constantly feeling tired, having low energy, feeling listless.)
- 9. Depression/Mood Problems** (A state of intense sadness that **lasts for more than two weeks**, and has advanced to the point of interfering with daily life - feeling "down", being tired, or feeling irritable for no apparent reason.)
- 10. Shoulder problems** (This includes pain in the shoulder joints and/ or muscles. People who must overuse a particular muscle group, such as shoulder muscles, or who put too much strain on their joints are at risk of developing pain.)
- 11. Spasticity** (Spontaneous and uncontrolled, jerky muscle movements, such as uncontrolled muscle twitch or spasm. Often spasticity increases with infection or some kind of restriction, like a tight shoe or belt.)
- 12. Joint contractures** (Limitation in range of motion caused by a shortening of the soft tissue around a joint, such as an elbow or hip. This occurs when a joint cannot move frequently enough through its range of motion. Pain often accompanies this problem.)
- 13. Bone fractures** (Broken bones.)
- 14. Osteoarthritis/degenerative arthritis** ("Wear and tear" on joints causing pain, swelling, and reduced movement/function of the joint.)
- 15. Sexual dysfunction** (This includes dissatisfaction with sexual functioning. Causes for dissatisfaction can be decreased sensation, changes in body image, difficulty in movement, and problems with bowel or bladder, like infections.)
- 16. Cerebrovascular disease, stroke, trans-ischemia attack (i.e. TIA)** (Permanent or temporary loss or reduction of brain function due to an interruption of blood flow to the brain.)
- 17. Heart Disease** (An umbrella term for a variety of diseases affecting the heart including: heart attack, angina [i.e. chest pain], heart failure, coronary artery disease.)
- 18. Diabetes** (Diabetes is a problem resulting from irregularities in blood sugar levels. Symptoms include frequent urination and excessive thirst. This condition is diagnosed by a physician.)

## Health Care ~~Utilisation~~Utilization Measure

The following are questions about your contact with the health care system. (if this is your ~~1st~~ <sup>1st</sup> year first Community Follow-up survey please ~~only~~ consider the time since discharge from your initial in-patient hospital stay [including acute care and/or rehab].)

**1. In the past 12 months, have you been a patient, overnight, in a hospital?**

- ☐ Yes
- ☐ No (skip to Question 3 on page 27)

**2. For how many nights in the past 12 months?** (if exact number is unknown, please estimate)

\_\_\_\_\_

**3. — In the past 12 months, not counting when you were an overnight patient in a hospital, how many times have you seen or talked on the telephone to the professionals listed below? Include any appointments or phone calls where your physical, emotional, or mental health, or your need for social services was treated/discussed with a:**

(if exact number is unknown, please estimate)

<input type="checkbox"/> Case Manager	_____ times
<input type="checkbox"/> Drug Alcohol Counsellor	_____ times
<input type="checkbox"/> Family Doctor/General Practitioner	_____ times
<input type="checkbox"/> Nurse	_____ times
<input type="checkbox"/> Nutritionist/Dietician	_____ times
<input type="checkbox"/> Occupational Therapist	_____ times
<input type="checkbox"/> Orthotist/Prosthetist	_____ times
<input type="checkbox"/> Psychiatrist/Psychologist	_____ times
<input type="checkbox"/> Physiatrist (Rehab doctor)	_____ times
<input type="checkbox"/> Physiotherapist	_____ times
<input type="checkbox"/> Recreational Therapist	_____ times
<input type="checkbox"/> Respiratory Therapist	_____ times
<input type="checkbox"/> Respirologist	_____ times
<input type="checkbox"/> SCI Peer Support Person	_____ times
<input type="checkbox"/> Sexual Health Clinician	_____ times
<input type="checkbox"/> Social Worker	_____ times
<input type="checkbox"/> Speech Language Pathologist	_____ times
<input type="checkbox"/> Spine Surgeon	_____ times
<input type="checkbox"/> Urologist	_____ times
<input type="checkbox"/> Vocational Counsellor	_____ times
<input type="checkbox"/> Wound Care Nurse/Specialist	_____ times
<input type="checkbox"/> Other (specify): _____	_____ times
<input type="checkbox"/> Other (specify): _____	_____ times
<input type="checkbox"/> Other (specify): _____	_____ times

☐ ~~I haven't spoken with any health professionals.~~

**3. Number of Emergency Department visits in past 12 months:** (if exact number is unknown, please estimate)

\_\_\_\_\_

**4. During the past 12 months, was there ever a time when you felt that you needed health care but didn't receive it?**

- ☐ Yes
- ☐ No (skip to SF-~~36v2™-12~~ on page ~~2028~~)

**5. How many times in the past 12 months did this occur?** (if exact number is unknown, please estimate)

\_\_\_\_\_

**6. Thinking of the most recent time, why didn't you receive care?** (check ALL that apply)

- ☐ Not available in my area
- ☐ Not available at the time (doctor on holiday, inconvenient hours)
- ☐ Waiting time too long
- ☐ Felt it would be inadequate
- ☐ Cost
- ☐ Too busy
- ☐ Didn't get around to it/Didn't bother
- ☐ Didn't know where to go
- ☐ Transportation problems
- ☐ Language problems
- ☐ Personal or family responsibilities
- ☐ Dislike doctor/afraid
- ☐ Decided not to seek care
- ☐ Facilities inaccessible/inadequate care due to environmental barriers in facility
- ☐ Other (specify): \_\_\_\_\_

**7. Again, thinking of the most recent time, what was the type of care that was needed?** (check ALL that apply)

- ☐ Regular check-up
- ☐ Care of an injury (e.g., burns, broken bones, cuts, concussions)
- ☐ Physical health problem (e.g., high blood pressure, pneumonia)
- ☐ Emotional/ mental health problem

☐ Other (specify): \_\_\_\_\_

## SF-12v2™ Health Survey

### Your Health and Well-Being

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. *Thank you for completing this survey!*

For each of the following questions, please mark the one box that best describes your answer.

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

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

#### 2. 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) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### 3. 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) Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b) Were limited in the kind of  
work or other activities

☐ ☐ ☐ ☐ ☐

**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 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) Accomplished less  
than you would like

☐ ☐ ☐ ☐ ☐

b) Did work or other activities  
less carefully than usual

☐ ☐ ☐ ☐ ☐

**5. 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

☐ ☐ ☐ ☐ ☐

**6. These questions are about how you have 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) Have you felt calm  
and peaceful?

☐ ☐ ☐ ☐ ☐

b) Did you have a lot of  
energy?

☐ ☐ ☐ ☐ ☐

c) Have you felt downhearted  
and depressed?

☐ ☐ ☐ ☐ ☐

**7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.?)**

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

☐ ☐ ☐ ☐ ☐

*Thank you for completing these questions!*

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(SF-12v2® Health Survey Standard, Canada (English))

**SF-36v2™**

Instructions: This survey asks you for your views about your health. 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, and check the box that best describes your answer.

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

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

**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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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) Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## INTERVIEW/MAIL

CQ-CFU

Page 39 of 49

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
| f)-Bending, kneeling, or stooping                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g)-Walking <u>more than a kilometer (mile)</u>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h)-Walking <u>several hundred metres (yards)</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i)-Walking <u>one hundred metres (yards)</u>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j)-Bathing or dressing yourself                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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<br>time       | Most of the<br>time      | Some of<br>the<br>time   | A little of<br>the time  | None of<br>the time      |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a)-Cut down on the <u>amount of time</u> you spent on work or other activities                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b)-Accomplished <u>less</u> than you would like  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c)-Were limited in the <u>kind of</u> work or other activities                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d)-Had <u>difficulty</u> performing the work or other activities (for example, it took extra effort) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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<br>time       | Most of the<br>time      | Some of<br>the time      | A little of<br>the time  | None of<br>the time      |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a)-Cut down on the <u>amount of time</u> you spent on work or other activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b)-Accomplished <u>less</u> than you would like                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c)-Did work or activities <u>less carefully than usual</u>                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**6. During the past four weeks, to what extent have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours 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  
timeMost of  
the timeSome of  
the timeA little of  
the timeNone of the  
time

a) Did you feel full of life?

☐☐☐☐☐

b) Have you been very nervous?

☐☐☐☐☐

c) Have you felt so down in the dumps that nothing could cheer you up?

☐☐☐☐☐



## INTERVIEW/MAIL

CQ-CFU

Page 41 of 49

d) Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Have you felt downhearted and depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Have you been happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**10. During the past 4 weeks, how much of the time have 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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## Craig Hospital Inventory of Environmental Factors (CHIEF®)—Short Form

Being an active, productive member of society includes participating in such things as working, going to school, taking care of your home and being involved with family and friends in social, recreational and civic activities in the community. Many factors can help or improve a person's participation in these activities while other factors can act as barriers and limit participation.

### Section A

First of all, do you think you have had the same opportunities as other people to participate in and take advantage of:

1) Education ☐—Yes ☐—No

## INTERVIEW/MAIL

CQ-CFU

Page 42 of 49

2)-Employment ☐-Yes ☐-No3)-Recreation/leisure ☐-Yes ☐-No**Section B**

How often has each of the following been a barrier to your own participation in the activities that matter to you? Think about the **past year**, and decide whether each item on the list below has been a problem **daily, weekly, monthly, less than monthly or never**. If the item occurs, then answer the question as to how big a problem the item is with regard to your participation in the activities that matter to you.

-

Note: If a question asks specifically about **school or work** and you neither work nor attend school, answer **not applicable**.

	Daily	Weekly	Monthly	Less than monthly	Never	Not applicable	Big problem	Little problem
1. In the past 12 months, how often has the availability of transportation been a problem for you? When this problem occurs, has it been a big problem or a little problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
2. In the past 12 months, how often has the natural environment—temperature, terrain, climate—made it difficult to do what you want or need to do? When this problem occurs, has it been a big problem or a little problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
3. In the past 12 months, how often have other aspects of your surroundings—lighting, noise, crowds, etc.—made it difficult to do what you want or need to do? When this problem occurs, has it been a big problem or a little problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

## INTERVIEW/MAIL

CQ-CFU  
Page 43 of 49

4.—In the past 12 months, how often has the information you wanted or needed not been available in a format you can use or understand?

☐ ☐ ☐ ☐ ☐

When this problem occurs, has it been a big problem or a little problem?

☐ ☐

5.—In the past 12 months, how often has the availability of health care services and medical care been a problem for you?

☐ ☐ ☐ ☐ ☐

When this problem occurs, has it been a big problem or a little problem?

☐ ☐

6.—In the past 12 months, how often did you need someone else's help in your home and could not get it easily?

☐ ☐ ☐ ☐ ☐

When this problem occurs, has it been a big problem or a little problem?

☐ ☐

7.—In the past 12 months, how often did you need someone else's help at school or work and could not get it easily?

☐ ☐ ☐ ☐ ☐ ☐

When this problem occurs, has it been a big problem or a little problem?

☐ ☐

8.—In the past 12 months, how often have other people's attitudes toward you been a problem at home?

☐ ☐ ☐ ☐ ☐

When this problem occurs, has it been a big problem or a little problem?

☐ ☐

**Daily**   **Weekly**   **Monthly**   **Less than monthly**   **Never**   **Not applicable**   **Big problem**   **Little problem**

9.—In the past 12 months, how often have other people's attitudes toward you been a problem at school or work?

☐ ☐ ☐ ☐ ☐ ☐

When this problem occurs, has it been a big problem or a little problem?

☐ ☐

## INTERVIEW/MAIL

CQ-CFU  
Page 44 of 49

10. In the past 12 months, how often did you experience prejudice or discrimination?

☐ ☐ ☐ ☐ ☐

When this problem occurs, has it been a big problem or a little problem?

☐ ☐

11. In the past 12 months, how often did the policies and rules of businesses and organizations make problems for you?

☐ ☐ ☐ ☐ ☐

When this problem occurs, has it been a big problem or a little problem?

☐ ☐

12. In the past 12 months, how often did government programs and policies make it difficult to do what you want or need to do?

☐ ☐ ☐ ☐ ☐

When this problem occurs, has it been a big problem or a little problem?

☐ ☐

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### The General Self-Efficacy Scale (English version by Ralf Schwarzer & Matthias Jerusalem, 1995)

For each of the following statements, please check the choice that is closest to how true you think it is for you. The questions ask about your opinion. There are no right or wrong answers.

#### 1. I can always manage to solve difficult problems if I try hard enough.

☐ Not at all true ☐ Hardly true ☐ Moderately true ☐ Exactly true

#### 2. If someone opposes me, I can find the means and ways to get what I want.

☐ Not at all true ☐ Hardly true ☐ Moderately true ☐ Exactly true

#### 3. It is easy for me to stick to my aims and accomplish my goals.

☐ Not at all true ☐ Hardly true ☐ Moderately true ☐ Exactly true

#### 4. I am confident that I could deal efficiently with unexpected events.

☐ Not at all true ☐ Hardly true ☐ Moderately true ☐ Exactly true

#### 5. Thanks to my resourcefulness, I know how to handle unforeseen situations.

☐ Not at all true ☐ Hardly true ☐ Moderately true ☐ Exactly true

#### 6. I can solve most problems if I invest the necessary effort.

☐ Not at all true ☐ Hardly true ☐ Moderately true ☐ Exactly true

#### 7. I can remain calm when facing difficulties because I can rely on my coping abilities.

☐ Not at all true ☐ Hardly true ☐ Moderately true ☐ Exactly true

#### 8. When I am confronted with a problem, I can usually find several solutions.

☐ Not at all true ☐ Hardly true ☐ Moderately true ☐ Exactly true

~~9. If I am in trouble, I can usually think of a solution.~~~~☐ Not at all true~~~~☐ Hardly true~~~~☐ Moderately true~~~~☐ Exactly true~~~~10. I can usually handle whatever comes my way.~~~~☐ Not at all true~~~~☐ Hardly true~~~~☐ Moderately true~~~~☐ Exactly true~~**LISAT-11 Questionnaire**

Instructions: Here are a number of statements concerning how satisfied you are with different aspects of your life. For each of these statements please circle a number from 1-6, where 1 means very dissatisfying and 6 very satisfying.

	Very dissatisfying	Dissatisfying	Rather dissatisfying	Rather satisfying	Satisfying	Very satisfying
<b>1. My life as a whole is:</b>	1	2	3	4	5	6
<b>2. My vocational situation is:</b>	1	2	3	4	5	6
<b>3. My financial situation is:</b>	1	2	3	4	5	6
<b>4. My leisure situation is:</b>	1	2	3	4	5	6
<b>5. My contact with friends and acquaintances is:</b>	1	2	3	4	5	6
<b>6. My sexual life is:</b>	1	2	3	4	5	6
<b>7. My ability to manage my self-care</b> (dressing, hygiene, transfers, etc.) <b>is:</b>	1	2	3	4	5	6
<b>8. My family life is:</b> <input type="checkbox"/> Have no family	1	2	3	4	5	6
<b>9. My partner relationship is:</b> <input type="checkbox"/> Have no steady partner relationship	1	2	3	4	5	6
<b>10. My physical health is:</b>	1	2	3	4	5	6
<b>11. My psychological health is:</b>	1	2	3	4	5	6

## Needs Measure

To live a full life, people with spinal cord injuries (SCI) have disability-related needs that must be met.

We would like to find out more about **your spinal cord injury needs and how well they are being met.**

### Are the following needs for services (to support your community living) being met at this time?

<a href="#">Accessible Housing</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
<a href="#">Attendant Care</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
<a href="#">Income Support</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
<a href="#">Equipment and Technical Aids</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
<a href="#">Short Distance Transportation</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
<a href="#">Long Distance Transportation</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
<a href="#">SCI-SpecialisedSpecialized Health Care</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
<a href="#">General Health Care</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
<a href="#">Emotional Counselling</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
<a href="#">Case Management</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
<a href="#">SCI Peer Support</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
<a href="#">Job Training</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
<a href="#">Healthy Living, Recreational &amp; Leisure Programs</a>	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A

## INTERVIEW/MAIL

CQ-CFU

Page 47 of 49

Other: _____	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A
Other: _____	<input type="checkbox"/> To a great extent or completely	<input type="checkbox"/> To some extent	<input type="checkbox"/> Very little	<input type="checkbox"/> Not at all	<input type="checkbox"/> N/A

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INTERVIEW/MAIL	CQ-CFU
Page 48 of 49	

<del>Data Collection Details</del>		<del>Collection Point:</del>		<del>Community Follow Up Year (i.e., 1, 2, 5, 10):</del>	
		<del>Collection Method:</del>			
<del>Interviewer or Reviewer of Mail Version: (please print name)</del>		<del>Initial Here:</del>			

Please record the date you completed this questionnaire:

				/			/		
YYYY					MM			DD	

*Thank you!*

Your continued participation in RHSCIR is very important.  
 People who work in the field of spinal cord injury use the information to provide better care today, and perform research that can lead to a cure tomorrow.

<del>FOR OFFICE USE ONLY:</del>					
<del>Data Collection Details</del>		<del>Collection Point:</del>		<del>Community Follow Up Year (i.e., 1, 2, 5, 10):</del>	
		<del>Collection Method:</del>			
<del>Interviewer or Reviewer of Mail Version: (please print name)</del>		<del>Initial Here:</del>			



INTERVIEW/MAIL

CQ-CFU  
Page 49 of 49