SERIAL NO:

APPENDIX 1

In STEP

(Individualised Support To Employment Participation)

Baseline Questionnaire

The answers given on this form are confidential.
Replies will only been seen by a small medical research team

Section One: About You

1. Please fill in your date of birth

Day ***Month*** ***Year***

2. And your sex

Male ☐ Female ☐

3. Please indicate your ethnic origin *(Tick one box)*

a) White ☐ b) Black-Caribbean ☐ c) Black-African ☐

d) Black-Other ☐ e) Indian ☐ f) Pakistani ☐

g) Bangladeshi ☐ h) Chinese ☐ i) Other *(please specify)* ☐

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4. What is your current marital status? *(Tick one box)*

a) Married ☐ b) Single ☐ c) Civil partnership ☐

d) Widowed ☐ e) Divorced ☐ f) Living with a partner ☐

5. At what age did you leave school?

Years old

6. Did you go on from school to further education or university? No ☐ Yes ☐

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

a) O Levels/GCSEs (or equivalents) ☐ b) A Levels (or equivalents) ☐

c) Vocational training certificate(s) (e.g. City and Guilds, NVQ) ☐ d) University degree(s) or HND ☐

e) Higher professional qualifications (e.g. in accountancy, law, etc) ☐

Section One: About You

8. Have you ever had a paid job? *(Tick one box)*

a) No ☐ b) Yes ☐

If you <u>have never had</u> a paid job, please go to ***Question 12***

If you <u>have had</u> a paid job in the past, please continue with ***Question 9***

9. We are interested to find out about all the paid jobs that you have carried out for more than 6 months and for at least 2 days (or 15 hours) a week since finishing full-time education

	Year Started	Year Finished	Name of Job	Industry of Job (e.g. office, shop, hospital)	Reason for Leaving

10. Thinking about your last job *(from question 9)***, did you leave because of your pain or another health problem?** *(Tick one box)*

a) No, not at all ☐

b) Yes, my pain or another health problem was **<u>the main</u>** reason for leaving ☐

c) Yes, my pain or another health problem was **<u>part of</u>** the reason for leaving ☐

11. If you *did* leave work because of a health problem, what type of problem was it? (*Tick all the boxes that apply*)

a) Chronic pain ☐ b) A problem with your back, neck, arm, shoulder or leg ☐ c) A mental health problem or stress ☐

Section One: About You

d) A problem with your heart or lungs ☐ e) Another type of health problem ☐ f) Not applicable, no health problem ☐

12. Thinking about trying to get back to work, what sort of work are you hoping for?

a) Part-time ☐ b) Full-time ☐

13. If *part-time*, what sort of hours per week are you hoping for?

a) 0-8 hours ☐ b) 9-15 hours ☐ c) 16-24 hours ☐ d) More than 25 hours ☐

14. AND ideally, what sort of job are you looking for?

a) _____

b) In which industry? *(e.g. shop, office, hospital)* _____

15. During your last period of unemployment, have you made any applications for jobs?

a) No ☐ b) Yes ☐

16. If yes, how many?

a) 0 ☐ b) 1 ☐ c) 2 - 10 ☐ d) 11 or more ☐

17. During your last period of unemployment, have you been for any job interviews?

a) No ☐ b) Yes ☐

18. If yes, how many?

a) 0 ☐ b) 1 ☐ c) 2 - 10 ☐ d) 11 or more ☐

19. Whilst you have been unemployed, have you accessed any support to help you find a job?

a) No ☐ b) Yes ☐

Section One: About You

20. If YES, what type of support *(Tick all that apply)*

a) A course to learn computer skills ☐

b) A course to develop your CV ☐

c) A course to develop your confidence ☐

d) Help from the Access to Work Scheme ☐

e) Advice from a work coach at the Job Centre Plus ☐

f) Job club ☐

g) Advice from the Citizen's Advice Bureau ☐

h) Any other service? ☐

Please describe

_____

21. Thinking about starting a new job, please indicate how certain you would feel about the following *(Please tick the box on each line that best matches your answer.)*

	Not at all certain	Fairly Uncertain	Neither certain nor uncertain	Fairly Certain	Completely Certain
a) How certain are you that you would be able to talk to your supervisor if you had problems when you returned to work?	☐	☐	☐	☐	☐
b) How certain are you that you would be able to discuss with your supervisor about things that contribute to pain?	☐	☐	☐	☐	☐
c) How certain are you that you would be able to explain your physical limitations to your supervisor?	☐	☐	☐	☐	☐
d) How certain are you that you would be able to suggest ways that you could reduce your discomfort to your supervisor?	☐	☐	☐	☐	☐
e) How certain are you that you would be able to remain in a job once back at work?	☐	☐	☐	☐	☐

Section One: About You

21. Thinking about starting a new job, please indicate how certain you would feel about the following *(Please tick the box on each line that best matches your answer.)*

	Not at all certain	Fairly Uncertain	Neither certain nor uncertain	Fairly Certain	Completely Certain
f) How certain are you that you would be able to continue working despite pain?	☐	☐	☐	☐	☐
g) How certain are you that you would be able to avoid making your pain worse?	☐	☐	☐	☐	☐
h) How certain are you that you would be able to manage your pain effectively while you were at work?	☐	☐	☐	☐	☐
i) How certain are you that you would be able to get your co-workers to help you?	☐	☐	☐	☐	☐
j) How certain are you that you would be able to explain your physical limitations to co-workers?	☐	☐	☐	☐	☐
k) How certain are you that you would be able to perform/complete your work tasks?	☐	☐	☐	☐	☐

	Not at all certain	Fairly Uncertain	Neither certain nor uncertain	Fairly Certain	Completely Certain
l) How certain are you that you would be able to deal with the physical demands of work?	☐	☐	☐	☐	☐
m) How certain are you that you would be able to cope with work pressure?	☐	☐	☐	☐	☐

Section One: About You

	Not at all certain	Fairly Uncertain	Neither certain nor uncertain	Fairly Certain	Completely Certain
n) How certain are you that you would be able to deal with emotionally demanding situations?	☐	☐	☐	☐	☐
o) How certain are you that you would have no energy left to do anything else?	☐	☐	☐	☐	☐
p) How certain are you that you would be able to handle potential problems if they arose?	☐	☐	☐	☐	☐
q) How certain are you that you could cope with setbacks if they arose?	☐	☐	☐	☐	☐

Section Two: About your Health

22. In general how would you say your health is? *(Tick one box)*

a) Excellent ☐ b) Very good ☐ c) Good ☐ d) Fair ☐ e) Poor ☐

23. We would like to know if you have any other health problems now.

(For each question, please put a tick in one box)

	Yes	No	Not sure
a) Do you have high blood pressure?	☐	☐	☐
b) Do you have heart problems?	☐	☐	☐
c) Do you suffer from diabetes?	☐	☐	☐
d) Do you have kidney disease?	☐	☐	☐

Section One: About You

e) Have you had a stroke or “TIA”? ☐ ☐ ☐

f) Do you have arthritis? ☐ ☐ ☐

g) Do you have asthma or other lung problems? ☐ ☐ ☐

h) Do you suffer from anxiety or depression? ☐ ☐ ☐

i) Do you have liver or stomach problems? ☐ ☐ ☐

Section Two: Your Health *continued*

24. These are questions about how it is for you to find, understand and use information related to health, illness and medical care. *(Please tick the box on each line that best matches your answer.)*

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

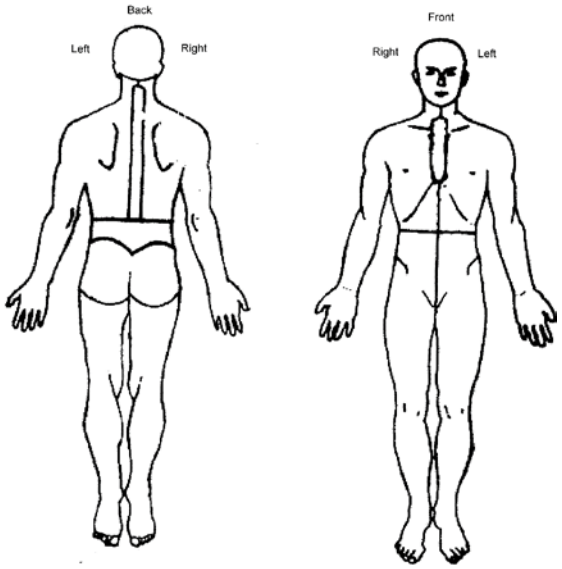
	Never	Rarely	Sometimes	Often	Always
g) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	☐	☐	☐	☐	☐

25. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain TODAY? *(Tick one box). If **NO**, please go to **Question 39.***

No ☐ b) Yes ☐

Section Two: Your Health *continued*

26. On the diagram, please shade in the areas where you feel pain. Put an X on the area that hurts



27. Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10

No pain — Pain as bad as you can imagine

28. Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10

No pain — Pain as bad as you can imagine

29. Please rate your pain by circling the one number that best describes your pain on AVERAGE.

0	1	2	3	4	5	6	7	8	9	10

No pain — Pain as bad as you can imagine

Section Two: Your Health *continued*

30. Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW

0	1	2	3	4	5	6	7	8	9	10

No pain — Pain as bad as you can imagine

31. What treatments or medications are you receiving for your pain?

a) _____ b) _____

c) _____ d) _____

32. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

No relief — Complete relief

33. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

C. Walking

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

D. Normal work (including both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10

Section Two: Your Health *continued*

Does not interfere — Completely interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

G. Enjoyment of Life

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

34. Please could you now indicate what the pain feels like? *(please circle those words that describe your pain)*

a)	aching	b)	throbbing	c)	shooting
d)	stabbing	e)	gnawing	f)	pricking
h)	sharp	i)	tender	j)	burning
k)	exhausting	l)	tiring	m)	penetrating
n)	nagging	o)	numb	p)	miserable
q)	unbearable	r)	dull	s)	radiating
t)	squeezing	u)	cramping	v)	deep

35. If you added up all the days when you had pain, how many in total would this be? *(please tick one box)*

Section Two: Your Health *continued*

a)	Less than a week	☐	b)	1 to 2 weeks	☐
c)	2 to 4 weeks	☐	d)	More than a month	☐

36. What kinds of things make you feel better? *(for example, heat, medicine, rest)*

_____

37. What kinds of things make you feel worse? *(for example, walking, standing, lifting)*

_____

38. Do you have any other symptoms? *(please circle those words that describe your pain)*

a)	nausea	b)	vomiting	c)	constipation
d)	lack of appetite	e)	indigestion	f)	difficulty sleeping
h)	feeling drowsy	i)	nightmares	j)	dizziness
k)	tiredness	l)	itching	m)	urinary problems
n)	sweating	o)	weakness	p)	headaches

39. Here are some of the things which other patients have told us about their pain. For each statement please circle a number from 0 to 6 to say how much physical activities such as bending, lifting, walking or driving affect or would affect *your* pain.

	Completely disagree		**Unsure**				**Completely agree**
a) My pain was caused by physical activity	**0**	**1**	**2**	**3**	**4**	**5**	**6**
b) Physical activity makes my pain worse	**0**	**1**	**2**	**3**	**4**	**5**	**6**

Section Two: Your Health *continued*

c) Physical activity might harm my pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**
d) I should not do physical activities which (might) make my pain worse	**0**	**1**	**2**	**3**	**4**	**5**	**6**
e) I cannot do physical activities which (might) make my pain worse	**0**	**1**	**2**	**3**	**4**	**5**	**6**

40. Below are some statements about feelings and thoughts. *(Please tick the box that best describes how you feel about yourself now).*

STATEMENT	Strongly Agree	Agree	Disagree	Strongly Disagree
a) I feel that I am a person of worth, at least on an equal plane with others	☐	☐	☐	☐
b) I feel that I have a number of good qualities	☐	☐	☐	☐
c) All in all, I am inclined to feel that I am a failure	☐	☐	☐	☐
d) I am able to do things as well as most other people	☐	☐	☐	☐
e) I feel I do not have much to be proud of	☐	☐	☐	☐
f) I take a positive attitude towards myself	☐	☐	☐	☐
g) On the whole, I am satisfied with myself	☐	☐	☐	☐
h) I wish I could have more respect for myself	☐	☐	☐	☐
i) I certainly feel useless at times	☐	☐	☐	☐

Section Two: Your Health *continued*

j) At times I think I am no good at all ☐ ☐ ☐ ☐

41. Over the past 2 weeks, how often have you been bothered by any of the following problems?

(Please circle one number for each row)	**Not at all**	**Several Days**	**More Than Half The Days**	**Nearly Every Day**
a) Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
b) Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
c) Trouble falling asleep, staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
d) Feeling tired or having little energy	**0**	**1**	**2**	**3**
e) Poor appetite or overeating	**0**	**1**	**2**	**3**
f) Feeling bad about yourself – or that you're a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
g) Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
h) Moving or speaking so slowly that other people could have noticed. Or, the opposite–being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
i) Thoughts that you would be better off dead or of hurting yourself in some way	**0**	**1**	**2**	**3**

42. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

a) Not difficult at all ☐ b) Somewhat difficult ☐ c) Very difficult ☐ d) Extremely difficult ☐

Section Two: Your Health *continued*

43. Below are some statements about feelings and thoughts. Please tick the box in each row that best describes your experience of each over the last <u>2 weeks</u> *(One tick for each row)*

	None of the time	Rarely	Some of the time	Often	All of the time
a) I've been feeling optimistic about the future	☐	☐	☐	☐	☐
b) I've been feeling useful	☐	☐	☐	☐	☐
c) I've been feeling relaxed	☐	☐	☐	☐	☐
d) I've been feeling interested in other people	☐	☐	☐	☐	☐
e) I've had energy to spare	☐	☐	☐	☐	☐
f) I've been dealing with problems well	☐	☐	☐	☐	☐
g) I've been thinking clearly	☐	☐	☐	☐	☐
h) I've been feeling good about myself	☐	☐	☐	☐	☐
i) I've been feeling close to other people	☐	☐	☐	☐	☐

Section Two: Your Health *continued*

	None of the time	Rarely	Some of the time	Often	All of the time
j) I've been feeling confident	☐	☐	☐	☐	☐
k) I've been able to make up my own mind about things	☐	☐	☐	☐	☐
l) I've been feeling loved	☐	☐	☐	☐	☐
m) I've been interested in new things	☐	☐	☐	☐	☐
n) I've been feeling cheerful	☐	☐	☐	☐	☐

44 Under each heading, please tick the ONE box that best describes your health TODAY

a) **MOBILITY**

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

b) **SELF CARE**

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

c) **USUAL ACTIVITIES (e.g. work, study,**

d) **PAIN / DISCOMFORT**

Section Two: Your Health *continued*

housework, family or leisure activities)

I have no problems doing my usual activities	☐	I have no pain or discomfort	☐
I have slight problems doing my usual activities	☐	I have slight pain or discomfort	☐
I have moderate problems doing my usual activities	☐	I have moderate pain or discomfort	☐
I have severe problems doing my usual activities	☐	I have severe pain or discomfort	☐
I am unable to do my usual activities	☐	I have extreme pain or discomfort	☐

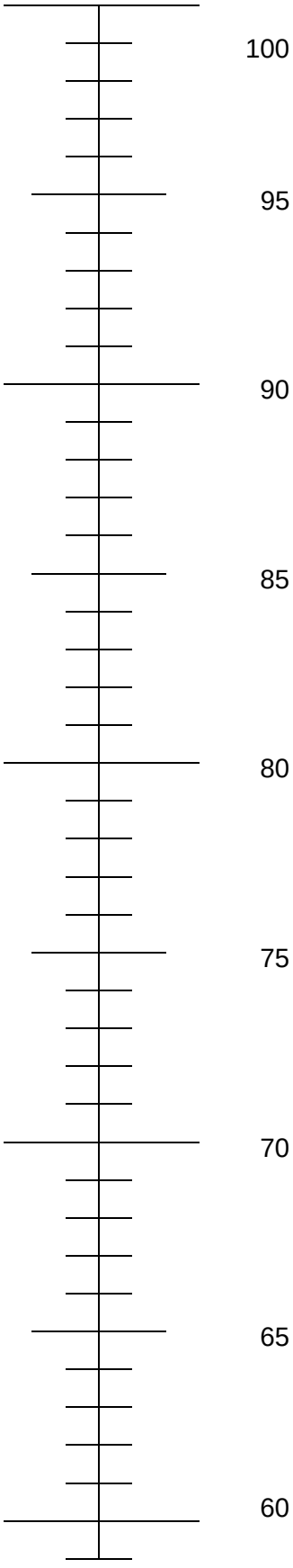
e) **ANXIETY / DEPRESSION**

I am not anxious or depressed	☐
I am slightly anxious or depressed	☐
I am moderately anxious or depressed	☐
I am severely anxious or depressed	☐
I am extremely anxious or depressed	☐

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

Section Two: Your Health *continued*

The best health you can imagine



This scale is numbered from 0 to 100

100 means the best health you can imagine

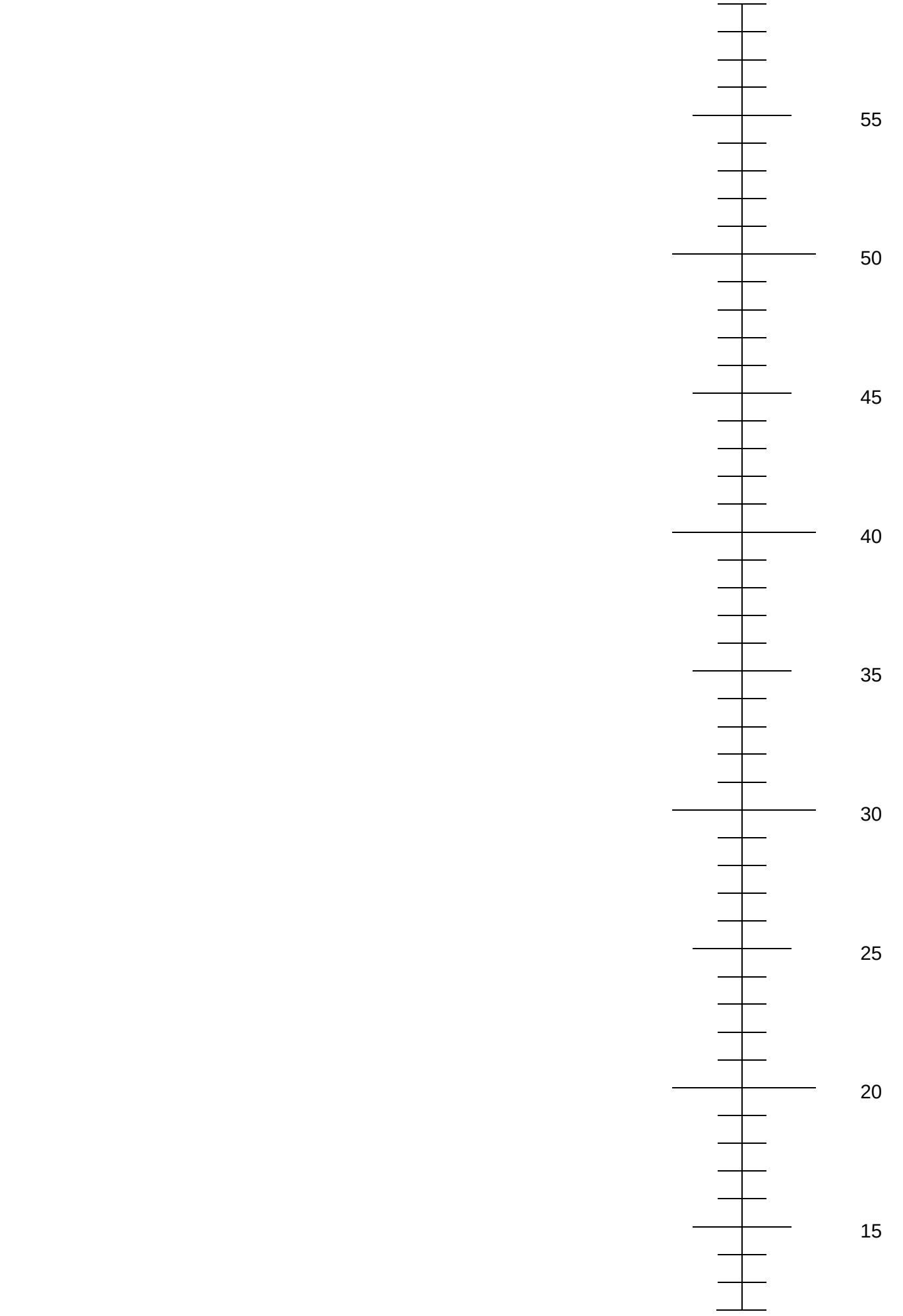
0 means the worst health you can imagine

Mark an X on the scale to indicate how your health is TODAY

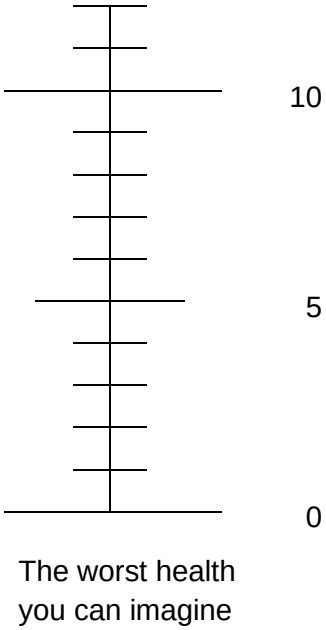
Now, please write the number you marked on the scale in the box below

YOUR HEALTH TODAY = ☐

Section Two: Your Health *continued*



Section Two: Your Health *continued*



Section Three: Your Healthcare

46. <u>In the last three months</u>, have you been to hospital <u>because of your pain</u>?

(Please tick "yes" or "no" for each line. If you answer "yes" to any of them please tell us how many times you used the service.)

	No	Yes		
Been to accident and emergency (casualty)	☐	☐	Total number of visits	☐☐
Stayed in hospital overnight	☐	☐	Total number of nights	☐☐
Had a hospital outpatient appointment	☐	☐	Total number of appointments	☐☐
Been treated as a hospital day case	☐	☐	Total number of days	☐☐

47. <u>In the last three months</u>, have you used any of the services below <u>because of your pain</u>?

Please tick "yes" or "no" for each line. If you answer "yes" to any of them please tell us how many times you used the service, how long your contact with that person lasted (on average if more than once) and when applicable tick if the service was private.

	No	Yes	No of times	On average, how many minutes did you see/talk to them for?
GP and practice nurse				
Saw GP at the surgery	☐	☐	☐☐	☐☐☐
Saw GP at home	☐	☐	☐☐	☐☐☐
Phoned GP for advice	☐	☐	☐☐	☐☐☐
Saw practice nurse	☐	☐	☐☐	☐☐☐
Phoned practice nurse for advice	☐	☐	☐☐	☐☐☐
Got a repeat prescription	☐	☐	☐☐	☐☐☐

Section Three: Your Healthcare

(without seeing doctor)

Social Services

Got meals on wheels	☐	☐		☐☐	☐☐☐
Home help came round	☐	☐		☐☐	☐☐☐
Saw social worker	☐	☐		☐☐	☐☐☐
Physiotherapist			**Private**		
Saw at the hospital	☐	☐	☐	☐☐	☐☐☐
Saw at home	☐	☐	☐	☐☐	☐☐☐
Saw at the GP surgery or a clinic	☐	☐	☐	☐☐	☐☐☐
Occupational therapist					
Saw at the hospital	☐	☐	☐	☐☐	☐☐☐
Saw at home	☐	☐	☐	☐☐	☐☐☐
Saw at the surgery or a clinic	☐	☐	☐	☐☐	☐☐☐

	No	**Yes**	**Private**	**No of times**	**On average, how many minutes did you see/talk to them for?**
Other services					
Pain self-management session	☐	☐	☐	☐☐	☐☐☐
Others *(e.g. alternative therapies voluntary services)*	☐	☐	☐	☐☐	☐☐☐

Section Three: Your Healthcare

48. <u>In the last three months</u>, have you, your relatives/friends, the NHS or social services paid for any of the following because of your pain?

(Please tick "yes" or "no" for each line and tell us how much it cost.)

	No	Yes	How much has this cost altogether in the last 3 months?	Who paid for this?
Employing extra help *(e.g. childcare or cleaning)*	☐	☐	£ _____	_____
Transport to get healthcare *(e.g. to go to your GP surgery or hospital)*	☐	☐	£ _____	_____
Transport to get to pain self-management sessions	☐	☐	£ _____	_____
Changes to your home *(e.g. moving bathroom downstairs, stairlift)*	☐	☐	£ _____	_____
Special equipment *(not mentioned above)*	☐	☐	£ _____	_____
Any other costs due to pain	☐	☐	£ _____	_____

49. <u>In the last three months</u>, have friends or relatives helped you with tasks at home which you couldn't do <u>because of your pain</u>?

No ☐ Yes ☐

*If **yes**, please tick below the tasks they helped you with and for how many hours per week.*

	No	Yes	Typically how many hours per week
Personal care *(e.g. bathing, dressing)*	☐	☐	☐☐

Section Three: Your Healthcare

49. <u>In the last three months</u>, have friends or relatives helped you with tasks at home which you couldn't do <u>because of your pain</u>?

Child care	☐	☐	☐☐
Housework / laundry	☐	☐	☐☐
Providing transport / taking you out	☐	☐	☐☐
Preparing meals	☐	☐	☐☐
Gardening	☐	☐	☐☐
Shopping	☐	☐	☐☐

	No	**Yes**	**Typically how many hours per week**
Looking after pets	☐	☐	☐☐
Generally providing support	☐	☐	☐☐
Other *(Please describe below)*	☐	☐	☐☐

This section is about the health care you have had over the PAST 4 WEEKS

50. Over the <u>PAST 4 WEEKS</u>, have you taken any medicines prescribed by a doctor for your pain?

No ☐ Yes ☐

Section Three: Your Healthcare

50. **Over the PAST 4 WEEKS, have you taken any medicines prescribed by a doctor for your pain?**

If yes, *please list these, giving the name of the medicine and number of days on which you took it*

Name of Medicine	**Number of days in total in which you took the medication**
	days
	days
	days
	days
	days

51. **Over the PAST 4 WEEKS, have you taken any complementary medicine for your pain (for example, glucosamine sulphate or cod liver oil)?**

No ☐ Yes ☐

If yes, *please list these, giving the name of the medicine and number of days on which you took it*

Name of Medicine	**Number of days in total in which you took the medication**
	days
	days

Section Three: Your Healthcare

51. **Over the PAST 4 WEEKS, have you taken any complementary medicine for your pain (for example, glucosamine sulphate or cod liver oil)?**

		days
		days

52. **Over the PAST 4 WEEKS, have you taken any other medicines (e.g. that you bought at a chemist) for your pain?**

No ☐ Yes ☐

If yes, *please list these, giving the name of the medicine and number of days on which you took it*

Name of Medicine	**Number of days in total in which you took the medication**
	days
	days
	days
	days
	days

53. **Over the PAST 4 WEEKS, have you received treatment from a complementary therapist for your pain?**

No ☐ Yes ☐

Section Three: Your Healthcare

53. **Over the PAST 4 WEEKS, have you received treatment from a complementary therapist for your pain?**

If yes, *please give details below*

Chiropractor ☐ times

Osteopath ☐ times

Other complementary therapist (please specify ☐ times

☐

Other complementary therapist (please specify) ☐ times

☐

Section Four: Personal Circumstances

54. How many adults (including yourself) live in your household? ☐☐

55. And how many children under 18 years old? ☐☐

56. Roughly how much of the total household income comes from money which you personally earn in a paid job or receive in benefits?

(Please do not include any money that you receive from pensions or investments) (Tick one box)

a) None ☐ b) Less than a quarter ☐ c) Between a quarter and a half ☐

d) Half or more ☐

57. Is anyone outside your household financially dependent on you? *(Tick one box)*

a) Yes ☐ b) No ☐

58. Is your home …. *(Tick the box that best applies)*

a) Owned outright by you or someone else in the household? ☐

b) Owned by you or someone else in the household, but with a mortgage? ☐

c) Rented? ☐

d) Rent free? ☐

e) Other? *(please specify)* ☐

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59. How well do you feel you are managing financially these days? *(Tick the box that best applies)*

a) Living comfortably ☐

b) Doing alright ☐

Section Four: Personal Circumstances

c) Just about getting by ☐ d) Finding it difficult to make ends meet ☐

e) Finding it very difficult to make ends meet ☐

60. Are there things which you used to have, and which you would like to have now, but can no longer afford? *(Tick one box)*

a) No ☐ b) A few things ☐ c) Many things ☐

61. Are there things which your friends or family have, that you would like to have but cannot afford? *(Tick one box)*

a) No ☐ b) A few things ☐ c) Many things ☐

62. Do you receive any state benefits?

No ☐ Yes ☐

If yes, *please tick below which benefits you get and tell us how much you get altogether*

a) Income support ☐ b) Invalidity allowance ☐

c) Family credit ☐ d) Disability working allowance ☐

e) Jobseeker's allowance ☐ f) Working tax credit ☐

g) Housing benefit ☐ h) Employment support allowance ☐

i) Statutory sick pay ☐ j) Personal Independence allowance ☐

Section Four: Personal Circumstances

k) Universal credit ☐ l) Carers allowance ☐

m) Others ☐ *(please specify)* ----------

n) **How much do you receive altogether in benefits each week?** **£** _____

63. What is the total income of your <u>household per week from all sources before taxes and deductions</u>? (Excluding housing benefit and council tax rebate)

Note: a household is either one person living alone, or a group of people (who may or may not be related) living, or staying temporarily, at the same address, with common housekeeping.

Please tick one box

a) £0-£99 (£0 - £5,199 per year) ☐ b) £350-£449 (£18,200 - £23,399 per year) ☐

c) £100-£149 (£5,200-£7,799 per year) ☐ d) £450-£599 (£23,400 - £31,199 per year) ☐

e) £150-£249 (£7,800-£12,999 per year) ☐ f) £600-£749 (£31,200 - £38,999 per year) ☐

g) £250-349 £13,000-£18,199 per year) ☐ h) £750 or more (£39,000 or more per year) ☐

64. Please give your height and your weight

Height ☐ ft ☐☐ ins or ☐☐☐ cm

Weight ☐☐ st ☐☐ lbs or ☐☐☐ kg

Section Four: Personal Circumstances

65. Using the units shown below please tell us what your alcohol consumption is. *(Please circle one number on each line)*

						
	Pint of Regular Beer/Lager/Cider	Alcopop or can of lager	Glass of Wine (175 ml)	Single measure of spirits	Bottle of wine	
	Remember, drinks poured at home are usually bigger					

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
a) How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	**0**	**1**	**2**	**3**	**4**
b) How often during the last year have you failed to do what was normally expected from you because of your drinking?	**0**	**1**	**2**	**3**	**4**
c) How often during the last year have you been unable to remember what happened the night before because you had been drinking?	**0**	**1**	**2**	**3**	**4**
	No		**Yes, but not in the last year**		**Yes, during the last year**
d) Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	**0**	**1**	**2**	**3**	**4**

Section Four: Personal Circumstances

66. Have you ever smoked regularly *(at least once a day for a month or longer)***?**

a) No ☐ b) Yes ☐

67. If yes, how old were you when you first smoked regularly? ☐☐ years old

68. Do you still smoke regularly? *(Tick one box)*

a) No ☐ b) Yes ☐ *(If yes, go to Question 74)*

69. If No, how old were you when you last smoked regularly? ☐☐ years old

You have finished
Many thanks for all your help

If you have any comments you wish to make about these questions please write in the box below