

Baseline Questionnaire

E-PAtS Feasibility Study: Baseline Questionnaire

v1.1 27/02/18

Please complete the following questionnaire. Take as much time as you need. If you have any questions, please ask the Researchers:

Sam Flynn (tel: 07823 362152 or email S.Flynn.1@warwick.ac.uk)

Lucy Licence (tel: 07384 231421 or email: Lucy.Licence@warwick.ac.uk)

Once finished, please hand back to the Researcher or return to the study team in the envelope provided.

Form completed by _____

Date completed

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
d	d		m	m		y	y

Questions about your child with learning disability

We would now like to ask you some questions about your child with learning disability whom you named to our researcher.

1. Please indicate your relationship to the child with learning disability.

Please select ONE

Biological mother

Biological father

Adoptive mother

Adoptive father

Stepmother

Stepfather

Foster mother

Foster father

Grandmother

Grandfather

Other (please describe)



2. What is the gender of your child with learning disability?

Please select ONE



Male

Female

Prefer not to say

Prefer to self-describe (please describe below)

3. What is your child with learning disability's date of birth?

/ /

d d m m y y

4. Please select which of the conditions below professionals have diagnosed, or have told you might apply, to your child with learning disability (select ALL that apply)

Select ALL that apply

Learning disability/learning difficulty

Autism/Autistic Spectrum Disorder /Autistic Spectrum Condition/Asperger's Syndrome

Down syndrome



Global Developmental delay/developmental delay
Cerebral palsy
Other genetic syndrome/other diagnosis (please describe below)

5. Who initially raised concerns about your child's development?

Please select ONE

You or a member of the family
School / nursery
Doctor / nurse / midwife / health visitor
Social worker
Other (please describe below)

6. Does your child with learning disability have a visual impairment?

Please select ONE

Yes
No

7. Does your child with learning disability have a hearing impairment?

Please select ONE

Yes
No

8. Does your child with learning disability currently have epileptic seizures?

Please select ONE

Yes (Please go to Question 9)
No (Please go to Question 10)

9. Has your child with learning disability ever had an epileptic seizure in the past?

Please select ONE

Yes
No

10. Does your child with learning disability have any other physical health problems?

Please select ONE

No
Yes (please describe)

11. Which of the following does your child with learning disability usually attend?

Please select ONE

Not currently in school or pre-school/nursery

Mainstream preschool or nursery

Mainstream preschool or nursery in a Special Education Needs (SEN) unit or similar

Mainstream school

Mainstream school in a Special Education Needs (SEN) unit or similar

Special school

Special preschool or nursery

Home schooled



12. Does your child with learning disability/autism normally...

Please select ONE

Live with you full-time? (Please go to Question 14)

Live with you part-time? (Please got to Question 13)



13. Please state the approximate number of days that your child with learning disability/autism lives with you on a weekly basis

Questions about you

14. How do you identify your gender?

Please select ONE

Male

Female

Prefer not to say

Prefer to self-describe (please describe below)



15. How would you describe your ethnicity?

Please select ONE

Asian/Asian British: Indian

Asian/Asian British: Pakistani

Asian/Asian British: Bangladeshi

Asian/Asian British: Chinese

Asian other (please describe)

Black/African/Black British: African

Black/African/Black British: Caribbean

Black other (please describe below)

Mixed/multiple ethnic groups: White and Black Caribbean

Mixed/multiple ethnic groups: White and Black African

Mixed/multiple ethnic groups: White and Asian

Mixed other (please describe)

Other Ethnic group: Arab

Ethnic other (please describe)

White: English/Welsh/Scottish/Northern Irish/British

White: Irish

White: Travelling community

White: Other (Please describe)

Any other ethnic background (Please describe)

Prefer not to say



16. Please select the highest level of your educational qualifications

Please select ONE

No qualifications

Some GCSEs passes or equivalent

5 or more GCSEs at A*-C or equivalent

5 A/AS Levels or equivalent

Higher Education but below degree level

Degree (e.g. BA, BSC, MA)

Don't know

Prefer not to say



17. Please select one option which best describes your status

Please select ONE

In a job and currently working for an employer

On maternity/paternity /parental leave from a job

Self-employed

A Full time student

Doing voluntary work

Looking after home and family

Unemployed

Do something else (please specify)

Prefer not to say



18. How is your health in general?

Please select ONE

Very good

Good

Fair

Bad

Very bad



19. Do you have a longstanding illness, disability or infirmity? By longstanding we mean anything that has troubled you over a period of time or is likely to affect you over a period of time?

Please select ONE

No

Yes



Questions about your household

20. In total how many people currently live in your home (including yourself and child with learning disability)?

	Adults	Children aged 13 years and under	Children aged 14 years and over
Number			

Data from research with families with a family member with a disability has shown that a family's financial resources are important in understanding family member's views and experiences. With this in mind, we would be grateful if you could answer the additional question below. We are not interested in exactly what your family income is, but we would like to be able to look at whether people with different levels of financial resources have different experiences.

21. What is your total weekly household income (after any deductions e.g. income tax), including income from paid work, pension, Social Services Benefits (e.g. Job Seekers Allowance, DLA, Carers' Allowance, Attendance Allowance, Tax Credits, Housing Benefits, Pension Credits) etc.?

Please select ONE

£200 or less

Between £201 and £300

Between £301 and £400

Between £401 and £500

Between £501 and £600

Between £601 and £700

Between £701 and £800

Between £801 and £900

Between £901 and £1000

Over £1000

✓

22. How well would you say you [and your husband/wife/partner] are managing financially these days?

Would you say you are ...

Please select ONE

living comfortably?

doing alright?

just about getting by?

finding it quite difficult?

finding it very difficult?

✓

23. Suppose you only had one week to raise £2000 for an emergency, which of the following best describes how hard it would be for you to get that money?

Please select ONE

I could easily raise the money

I could raise the money, but it would involve some sacrifices (e.g. reduced spending, selling a possession)

I would have to do something drastic to raise the money (e.g. selling an important possession)

I don't think I could raise the money



Questions about your experiences

24. The following statements ask about your experiences of having a child with learning disability.

Please respond to all questions by selecting the response which best describes how you feel about each statement.

Please tick ONE answer per statement

Strongly
agree

Agree

Neither
agree or
disagree

Disagree

Strongly
disagree

Since having this child I have grown as a person

Having this child has helped me learn new things/skills

Raising this child helps put my life into perspective

Since having this child, my family has become closer to one another

Since having this child, my family has become more tolerant and accepting

Since having this child I have become more determined to face up to challenges

Since having this child I have a greater understanding of other people

25. Warwick-Edinburgh Mental Well Being Scale-deleted due to copyright.

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2006, all rights reserved.

26. Hospital Anxiety and Depression Scale –deleted due to copyright.

27. EQ-5D- deleted due to copyright

28. The following items focus on the ways in which you cope with the more difficult aspects of having a child with learning disabilities in your family. There are many ways in which people will deal with these difficulties, and different people will use different ways of coping. We are interested in how YOU cope with these difficulties. Each item says something about a particular way of coping. We want to know to *what extent* you do what the item says in order to cope with the more difficult aspects of caring for a child with learning disabilities. Please do not answer on the basis of whether these ways of coping seem to *work* or not, but simply whether or not you do what the item says. Try to rate each item separately in your mind from the others, and make your answers as true FOR YOU as you can. Select your response by ticking ONE answer per statement.

Please select <u>ONE</u> answer per statement	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
I concentrate my efforts on doing something about the situation.				
I get emotional support from others.				
I give up trying to deal with it				
I take action to try to make the situation better				
I say things to let my unpleasant feelings escape.				
I get help and advice from other people.				
I try to see it in a different light, to make it seem more positive.				
I criticise myself.				
I try to come up with a strategy about what to do.				
I get comfort and understanding from someone.				
I look for something good in what is happening.				
I do something to think about it less, such as going to the cinema, watching TV, reading, daydreaming, sleeping or shopping.				
I accept the reality of the fact that it has happened.				
I express my negative feelings.				
I learn to live with the situation				
I think hard about what steps to take.				
I blame myself for things that happen.				

29. Listed below are sources that are often helpful to members of families raising a child with learning disabilities. We are interested in how helpful each source is to YOUR FAMILY.

Please *circle* the response that best describes how helpful each source has been to your family during the past SIX MONTHS. If a source of help has not been available to your family during this period of time, please circle the NA response (Not Available). If there have been other sources of help available to you during the past 6 months, please write in what these have been and rate each of them in the spaces provided.

Please circle <u>ONE</u> response per source	Not available	Not at all helpful	Sometimes helpful	Generally helpful	Very helpful	Extremely helpful
My parent(s)	NA	0	1	2	3	4
My partner's parent(s)	NA	0	1	2	3	4
My other relatives/kin	NA	0	1	2	3	4
My partner's other relatives/kin	NA	0	1	2	3	4
My partner (husband/wife)	NA	0	1	2	3	4
My friends	NA	0	1	2	3	4
My partner's friends	NA	0	1	2	3	4
My children	NA	0	1	2	3	4
Other parents I know	NA	0	1	2	3	4
My colleagues at work	NA	0	1	2	3	4
Parent groups/organisations	NA	0	1	2	3	4
Social groups/clubs	NA	0	1	2	3	4
People at church (or other religious organisation)	NA	0	1	2	3	4
The family's doctor (GP)	NA	0	1	2	3	4
Professional workers (social workers, therapists, teachers)	NA	0	1	2	3	4
Professional agencies (social services, education, child health etc).	NA	0	1	2	3	4
School/nursery/playgroup	NA	0	1	2	3	4
An early intervention programme	NA	0	1	2	3	4
Other (please describe)	NA	0	1	2	3	4
Other (please describe)	NA	0	1	2	3	4

30. Please rate the extent to which you agree or disagree with each of the following statements.

Please circle <u>ONE</u> response per statement	Strongly Disagree	Somewhat Disagree	Disagree	Agree	Somewhat Agree	Strongly Agree
The problems of taking care of your child with learning disability are easy to solve once you know how your actions affect your child, an understanding I have acquired	1	2	3	4	5	6
I would make a fine model for a new parent to follow in order to learn what they would need to know in order to be a good parent.	1	2	3	4	5	6
Being a parent is manageable, and any problems are easily solved.	1	2	3	4	5	6
I meet my own personal expectations for expertise in caring for my child.	1	2	3	4	5	6
If anyone can find the answer to what is troubling my child with learning disability, I am the one.	1	2	3	4	5	6

My talents and interests are in other areas, not being a parent.	1	2	3	4	5	6
Considering how long I've been a parent, I feel thoroughly familiar with this role.	1	2	3	4	5	6
I honestly believe I have all the skills necessary to be a good parent to my child with learning disability.	1	2	3	4	5	6

Questions about your relationship with a spouse/partner

We would now like to ask you about your relationship with a spouse / partner (this is a partner who you are currently living with) .

31. What is your current marital status?

Please select ONE

Married and living with spouse/civil partner

Living with partner

Divorced/Separated/Single/Widowed/Not currently living with partner (Please go to question 35)

32. How often do you and your [husband/wife/partner] disagree over issues relating to your child with learning disability?

Please select ONE

Never

Less than once a week

Once a week

Several times a week

Once a day

More than once a day

Can't say

33. For each statement, select the response that best describes the way you and your partner work together as parents:

Please circle <u>ONE</u> response per statement	Not true of us		A little bit true of us		Somewhat true of us		Very true of us	
My partner and I have the same goals for our child with learning disability.	0	1	2	3	4	5	6	
My partner and I have different ideas about how to raise our child with learning disability.	0	1	2	3	4	5	6	
My partner and I have different ideas regarding our child's eating, sleeping, and other routines	0	1	2	3	4	5	6	
My partner and I have different standards for our child's behaviour	0	1	2	3	4	5	6	

34. Here is a scale from 1-7 where '1' means that you are very unhappy and '7' means that you are very happy. Please circle the number which best describes how happy or unhappy you are with your relationship with your spouse/partner, all things considered?

Very unhappy							Very happy	Can't say
1	2	3	4	5	6	7	8	

Questions about your family

We would now like to ask you about how satisfied you are with family life.

35. Please read the following statements and select what best applies to you.

Please select ONE answer per statement

Almost **Some of** **Hardly**
always **the time** **ever**

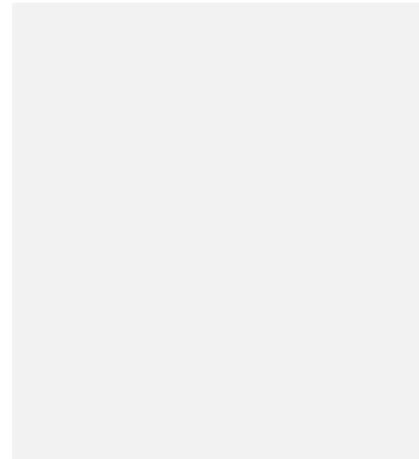
I am satisfied that I can turn to my family for help when something is troubling me

I am satisfied with the way my family talks over things with me and shares problems with me

I am satisfied that my family accepts and supports my wishes to take on new activities or directions

I am satisfied with the way my family expresses affection and responds to my emotions, such as anger, sorrow and love

I am satisfied with the way my family and I share time together



Questions about your relationship with your child with learning disability

We would now like to ask you about your relationship with your child with learning disability.

36. Please reflect on the degree to which each of the following statements currently applies to your relationship with your child with learning disability. Using the scale below, tick one appropriate answer for each item.

Please select ONE answer per statement

Definitely does not apply **Not really** **Neutral, not sure** **Applies somewhat** **Definitely applies**

I share an affectionate relationship with this child

This child and I always seem to be struggling with each other

If upset, this child will seek comfort from me

This child is uncomfortable with physical affection or touch from me

This child values his/her relationship with me

When I praise this child, he/she beams with pride

This child spontaneously shares information about himself/herself

This child easily becomes angry with me

It is easy to be in tune with what this child is feeling

This child remains angry or is resistant after being disciplined

Dealing with this child drains my energy

When this child is in a bad mood, I know we're in for a long difficult day

This child's feelings towards me can be unpredictable or change suddenly

This child is sneaky or manipulative with me

This child openly shares his/her feelings and experiences with me

We would now like to ask you about how often you do particular activities with your child with learning disability.

37. The following are a number of statements about you and your child with learning disability. Please rate each item as to how often it has typically occurred during the past six months.

Please select ONE answer per statement

Not at all	Less often than once or twice a month	Once or twice a month	Several times a week	Everyday
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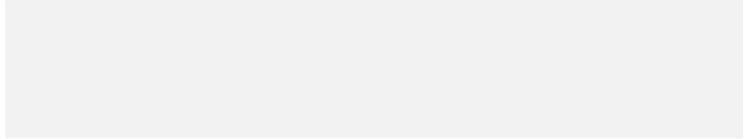
How often do you read or share a story with your child?

How often do you and your child sing together?

How often do you and your child play a game together?

How often do you and your child go out together for enjoyment? (rather than as a chore e.g. appointments/ food shopping etc.)

How often do you and your child
watch TV together?



Questions about your child's relationship with his/her siblings

38. Does your child with learning disability have at least one sibling between the ages of 4 to 16?

Please select ONE



Yes

No (Please skip to Question 45)

We would now like to ask about one of the siblings of your child with learning disability. If there is more than one sibling between the ages of 4-16, please choose the sibling closest in age to your child with learning disability

39. How old is your child's sibling in years and months?

Years

Months

40. What gender is your child's sibling?

Please select ONE



Male

Female

Prefer not to say

Prefer to self-describe (please describe below)

41. Does this sibling have a longstanding illness, disability or infirmity? By longstanding we mean anything that has troubled them over a period of time or is likely to affect them over a period of time?

Please select ONE



No

Yes

If yes, please describe

42. Does this sibling live in the same household as your child with learning disability?

Please select ONE



All of the time

Some of the time

None of the time

We would now like to ask about the strengths and difficulties of the sibling of your child with learning disability. If there are any items that do not apply to your child then please select 'Not true'.

43. Strengths and Difficulties Questionnaire-deleted due to copyright.

Strengths and Difficulties Questionnaire © Robert Goodman, 2005.

44. We would now like you to tell us about the relationship between your child with learning disability and their sibling you have just told us about.

Please select ONE answer per statement

**Hardly at
all**

**Not too
much**

**Somewh
at**

**Very
much**

**Extremely
much**

How much do the sibling and the child tell each other everything?

How much do the sibling and the child share secrets and private feelings?

How much do the sibling and the child go places and do things together?

Some siblings play around and have fun with each other a lot, while other siblings play around and have fun with each other a little. How much do the sibling and the child play around and have fun with each other?

Some siblings care about each other a lot while other siblings don't care about each other that much. How much do the sibling and the child care about each other?

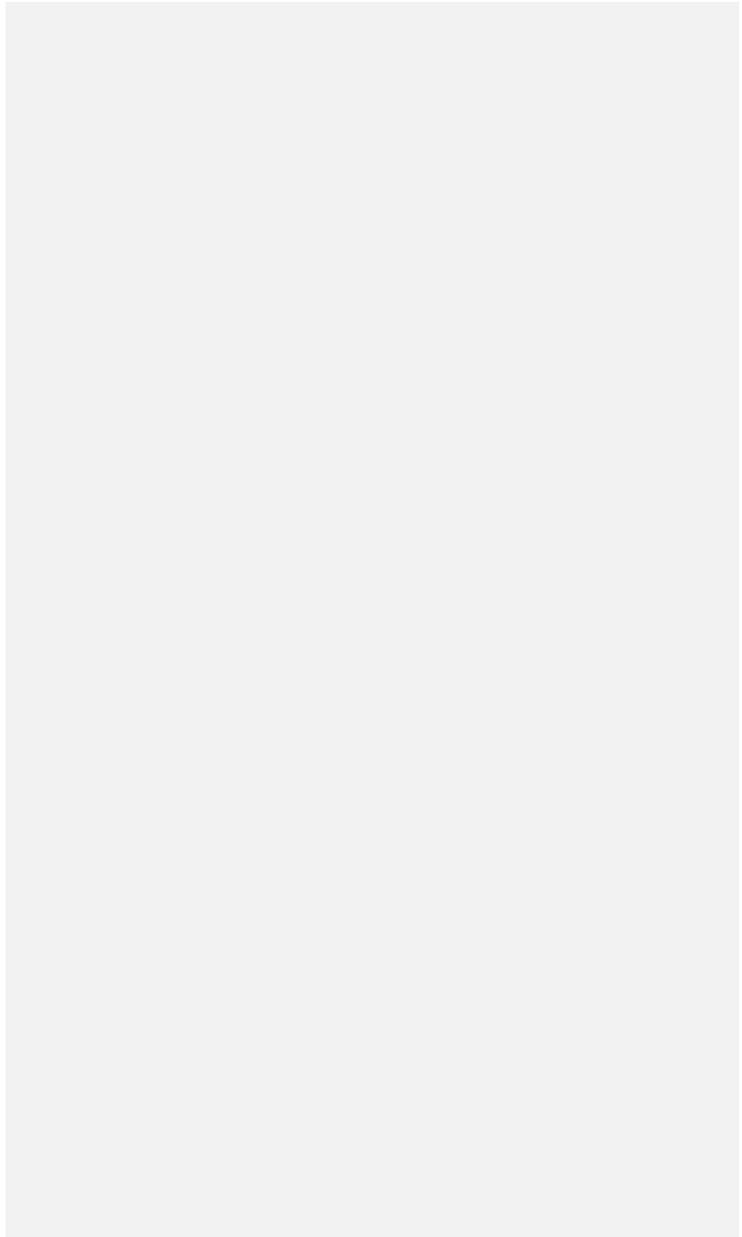
How much do the sibling and the child love each other?

How much do the sibling and the child disagree and quarrel with each other?

How much do the sibling and the child get mad and get in arguments with each other?

How much do the sibling and the child insult and call each other names?

How much are the sibling and the child mean to each other?



Questions about use of community-based services

The following questions ask about the services that you and your child with learning disabilities have used for any reason, the expenses incurred, and any help or support provided by your family and friends. Some questions will seem more relevant than others. Please try to answer all of the questions if possible. If you are unsure about any answers then please include as much as you can remember. The questionnaire also asks about your own health and wellbeing.

45. Could you tell us if your child has used any of the following health care, social care voluntary or private services over the past 3 months)?

Type of service	Have you used the service for your child? (please tick)		Total number of <u>face-to-face</u> contacts	Total number of contacts by <u>telephone or email</u>
GP, surgery visit	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
GP, out of hours visit	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
GP, home visit	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
GP Practice nurse	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Calls to NHS Direct	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
District nurse, or member of community health team	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Health visitor	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Paediatrician (child's doctor)	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Ophthalmology (eyesight)	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Audiology (hearing)	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Speech and language	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Psychologist	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Psychiatrist	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Dentist	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Child and adolescent mental health service provider	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Private childcare	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Nursery (please specify)	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Other health care services (please specify):	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
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Other social care services (please specify):	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
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Other voluntary services (please specify):	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

Other private services (please specify):

Y

N

46. Could you tell us if your child has used any of the following hospital or day services over the past 3 months?

Type of service

Yes / No

Name of hospital, name and type of ward, and town of service used

Total number of days your child was in each service

Total number of visits made to each service

Hospital inpatient stay

Y N

Name

.....

Type of

ward.....

Town

.....

Hospital day centre

Y N

Name

.....

Type of

ward.....

Town

.....

Hospital accident and emergency department

Y N

Name

.....

Type of

ward.....

Other hospital
outpatient clinic

Town
.....

Y N Name

.....

Type of
ward.....

Town
.....

Children's
development centre

Y N Name

.....

Type of
ward.....

Town
.....

Other children's day
centre

Y N Name

.....

Type of
ward.....

Town
.....



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47. Could you tell us about your child's use of medications over the past 3 months?

Name of medication

Number of times
taken per day

Number of
days used

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48. Could you tell us if you have used any of the following health care, social care voluntary or private services for yourself over the past 3 months?

Type of service	Have you used the service for your child? (please tick)		Total number of <u>face-to-face</u> contacts	Total number of contacts by <u>telephone or email</u>
GP, surgery visit	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
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GP, home visit	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
GP Practice nurse	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Calls to NHS Direct	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
District nurse	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Health visitor	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Social worker	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Physiotherapist	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Occupational therapist	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Home help or care worker	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Psychiatrist	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Psychologist	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Dentist	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Counsellor	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Family or patient support (please specify)	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Women's aid (please specify)	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Housing department services (please specify)	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Citizen's advice bureau (please specify)	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Other health care services (please specify):	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

Please continue on next page
 Other social care services (please specify):

Y N

Other voluntary services (please specify):

Y N

Other private services (please specify):

Y N

49. Could you tell us if you have used any of the following hospital or day services for yourself over the past 3 months?

Type of service	Yes / No	Name of hospital, name and type of ward, and town of service used	Total number of days you were in each this service	Total number of visits made to this service
-----------------	----------	---	--	---

Hospital inpatient stay

Y N Name

.....

Type of ward.....

Town

Hospital day centre

Y N Name

.....

Type of ward.....

Town

Hospital accident and
emergency
department

Y N Name

.....

Type of
ward.....

Town
.....

--	--	--

Other hospital
outpatient clinic

Y N Name

.....

Type of
ward.....

Town
.....

--	--	--

Day centre run by
your local authority

Y N Name

.....

Type of
ward.....

Town
.....

--	--	--

--	--	--

Other (please specify)

Y N Name

.....

Type of
ward.....

Town
.....

--	--	--

--	--	--

50. Could you tell us about your use of medications over the past 3 months)?

Name of medication	Number of times taken per day	Number of days used
_____	<input type="text"/>	<input type="text"/>
_____	<input type="text"/>	<input type="text"/>
_____	<input type="text"/>	<input type="text"/>
_____	<input type="text"/>	<input type="text"/>
_____	<input type="text"/>	<input type="text"/>

Questions 51 to 53 ask about the financial implications of changes to your or your child’s health status. This is to help us understand how much income people lose when their health status changes and how it affects them so that we can understand their problems. All information that you provide will be treated as confidential and will not be shared with anyone outside the research team

51. Please tick one box for the category that best describes your present employment status.

Employment Status. Please tick One category that best describes your employment now

- Employee
- Self-employed
- Employee on sick leave

52. Has your employment status changed over the last 3 months?

Please select ONE

- No
- Yes

52b. If you answered yes to the question above could you provide us with brief details in the box below. (For example, you could return to work after sick-leave but on a part-time base)

53. Have you lost days of work due to your or your child's health (exclude maternity or annual leave) over the last 3 months)?

Please select ONE

No

Yes

✓

53b. If you answered yes to the question above could you tell us how many days of work you lost?

Days out of work:

--	--	--

54. How much would you value in financial terms the earnings you lost whilst being out of work due to your or your child's health?

55. Have you incurred any additional expenses, e.g. child care costs over the last 3 months)?

Please select ONE

No

Yes

✓

55b If the answer is yes, please fill in the details in the table below.

Type of additional cost	Details	Total additional cost (£)			
Additional travel costs		<table border="1" style="display: inline-table;"> <tr> <td style="width: 30px; height: 30px;"> </td> <td style="width: 30px; height: 30px;"> </td> <td style="width: 30px; height: 30px;"> </td> </tr> </table>			
Additional child care costs		<table border="1" style="display: inline-table;"> <tr> <td style="width: 30px; height: 30px;"> </td> <td style="width: 30px; height: 30px;"> </td> <td style="width: 30px; height: 30px;"> </td> </tr> </table>			
Additional help with housework		<table border="1" style="display: inline-table;"> <tr> <td style="width: 30px; height: 30px;"> </td> <td style="width: 30px; height: 30px;"> </td> <td style="width: 30px; height: 30px;"> </td> </tr> </table>			
Additional expenses - please specify:		<table border="1" style="display: inline-table;"> <tr> <td style="width: 30px; height: 30px;"> </td> <td style="width: 30px; height: 30px;"> </td> <td style="width: 30px; height: 30px;"> </td> </tr> </table>			

Additional expenses - please
specify:

--	--	--

**Please now continue onto the next page and complete the following
questions attached to the back of this questionnaire**

56. PEDS-QL-Deleted due to copyright