

SPNS Program Cooperative Agreement Evaluation - Page 2 of 2
Module 17: Brief Health and Functioning Questionnaire
National Evaluation by The Measurement Group

ID Letters			ID Numbers						Site			Sub-Provider			Date					
<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"/> <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"/>					
									Month			Day			Year					
Staff Code			Client Gender						12. Last week, were you: <input type="radio"/> Working full time <input type="radio"/> Working part time <input type="radio"/> With a job, but not at work because of illness, vacation, or strike <input type="radio"/> Unemployed, laid off, or looking for work <input type="radio"/> Retired, disabled, or no longer working <input type="radio"/> In school <input type="radio"/> Keeping house <input type="radio"/> None of the above						13. How many hours did you work last week, at all jobs? <input type="radio"/> None <input type="radio"/> 36-45 hours <input type="radio"/> 1-20 hours <input type="radio"/> 46-60 hours <input type="radio"/> 21-35 hours <input type="radio"/> More than 60 hours How many? <input type="text"/> <input type="text"/> <input type="text"/>					
<input type="text"/> <input type="text"/> <input type="text"/>			<input type="radio"/> Male <input type="radio"/> Female																	
11. How many days during the past 4 weeks did your own illness, treatment, or a personal problem (like feeling depressed) cause you to do any of the following things?									14. Approximately what was your own personal income from all sources before taxes last month? <input type="radio"/> No income last month <input type="radio"/> \$1501-\$2000 last month <input type="radio"/> \$1-\$500 last month <input type="radio"/> \$2001-\$3000 last month <input type="radio"/> \$501-\$1000 last month <input type="radio"/> \$3001-\$4000 last month <input type="radio"/> \$1001-\$1500 last month <input type="radio"/> \$4001 or more ↘ How much? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>											
11A. Cut down on your usual activities (such as housework, school, leisure) for 1/2 day or more? <input type="radio"/> Did not cut down on activities <input type="radio"/> 5-8 days <input type="radio"/> 1 day <input type="radio"/> 9-14 days <input type="radio"/> 2 days <input type="radio"/> 15-28 days <input type="radio"/> 3-4 days																				
11B. Stay in bed for a half day or more? <input type="radio"/> Did not stay in bed <input type="radio"/> 5-8 days <input type="radio"/> 1 day <input type="radio"/> 9-14 days <input type="radio"/> 2 days <input type="radio"/> 15-28 days <input type="radio"/> 3-4 days									16. During the past 4 weeks, how many visits have you had from a doctor, nurse, or other paid health professional who came to your home or where you live now? (For example, a visiting nurse drawing blood or giving a shot.) <input type="radio"/> No visits <input type="radio"/> 5-8 visits <input type="radio"/> 1 visit <input type="radio"/> 9-14 visits <input type="radio"/> 2 visits <input type="radio"/> 15-28 visits <input type="radio"/> 3-4 visits <input type="radio"/> 29 or more visits			17. During the past 4 weeks, how many telephone contacts have you had with a doctor, nurse, or other health professional about your own health care? Do not count contacts that were only for making or changing appointments. <input type="radio"/> No contacts <input type="radio"/> 5-8 contacts <input type="radio"/> 1 contact <input type="radio"/> 9-14 contacts <input type="radio"/> 2 contacts <input type="radio"/> 15-28 contacts <input type="radio"/> 3-4 contacts <input type="radio"/> 29 or more contacts			18. In the past 4 weeks, how many nights did you stay overnight or longer in a hospital? <input type="radio"/> No nights <input type="radio"/> 1 night <input type="radio"/> 2 nights <input type="radio"/> 3-4 nights <input type="radio"/> 5-8 nights <input type="radio"/> 9-14 nights <input type="radio"/> 15-28 nights					
11C. Miss work for a half day or more? <input type="radio"/> Employed; Did not miss work <input type="radio"/> 5-8 days <input type="radio"/> 1 day <input type="radio"/> 9-14 days <input type="radio"/> 2 days <input type="radio"/> 15-28 days <input type="radio"/> 3-4 days <input type="radio"/> Not employed																				
19. Have you had any of the following symptoms in the past 4 weeks?									FOR EACH SYMPTOM YOU HAD: How much did it interfere with your normal activity in the past 4 weeks? (4 weeks = 28 days) I HAD IT AND IT INTERFERED:											
19a. Trouble with thinking, concentrating, or memory									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
19b. Depressed or sad; trouble sleeping									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
19c. Aches, fatigue, lightheadness, weak-all-over									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
19d. Fevers, chills, sweats									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
19e. Poor appetite, weight loss									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
19f. Trouble with eyes or ears									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
19g. Trouble with nose or sinuses; headache									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
19h. Trouble with mouth or swallowing									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
19i. Nausea, vomiting, diarrhea, abdominal pain									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
19j. Coughing, wheezing, or chest pain; trouble breathing									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
19k. Rash, itch, herpes, or other skin trouble									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
19l. Numbness, tingling, or pain in an arm or leg									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
19m. Other symptoms									<input type="radio"/> I did not have it at all			<input type="radio"/> Not at all <input type="radio"/> Very little <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely								
Which? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																				