# Appendix 11

# Development of Client Information Questionnaire data sources

## Client Information Questionnaire – questions and data sources

| Item | Question | Source | Modified/not modified | Comment |
|---|---|---|---|---|
| Sex | Are you male of female<br><br>Not 'What is your sex?' | National health data dictionary<br>ABS 1269.0 1998 | Modified | Different phasing of question.<br><br>Response types same |
| DOB | What is your date of birth | National health data dictionary<br>ABS 1269.0 1998 | | |
| COB | In which country were your born | Census 2001<br><br>National health data dictionary<br>ABS 1269.0 1998 | | |
| Language | Do you speak a language other than English at home? | Census 2001<br><br>ABS 1267.0 1997 | | |
| ATSI | Are you Aboriginal or Torres Strait Islander Origin? | Census 2001 | | |
| Marital status | What is your present marital status | Census 2001 | | |
| Number of babies | If you are female, how many babies have you had? | National Health Survey – Women's supplementary Health Form 2001 | | |
| Schooling | What is your highest level of primary or secondary school you have completed? | Census 2001 | | |

| Item | Question | Source | Modified/not modified | Comment |
|---|---|---|---|---|
| Qualification | What is your highest level of qualification that you have completed? | Census 2001 | | |
| Employment | How would you describe your current employment status | NSW health survey 1997/1998 | | |
| Occupation | It you are employed full or part time, what is your occupation | National evaluator<br><br>Coded using ABS 122.0 1997) | | Different phasing of question.<br><br>Response types same |
| Retired occupation | If you are retired, what was your main occupation? Than is the main occupation that you previously spent most time doing. | National evaluator<br><br>Coded using ABS 122.0 1997) | | Different phasing of question.<br><br>Response types same |
| Income sources | Do you receive income from any of these sources? | National Health data dictionary | | |
| Pension types | Do you currently receive any of these pensions, allowances or benefits? | National Health Survey 2001 | | |
| Living arrangements | What are your current living arrangements? | HACC minimum data set 1998 | | |
| Accommodation setting | Which of the following best describes the setting in which you live? | HACC minimum data set 1998 | Modified | Question same<br><br>Response types grouped |

| Item | Question | Source | Modified/not modified | Comment |
|---|---|---|---|---|
| Carer availability | A carer is a person who may be a family member, friend, relative or other who regularly helps you formally or informally with managing your life. | HACC minimum data set 1998 | Modified | Different phasing of question.<br><br>Response types same |
| Carer residence | If you have a carer, which of the following best describes them? | HACC minimum data set 1998 | Modified | Different phasing of question.<br><br>Response types same |
| Smoking | Which of the following best describes your smoking status? | NSW health survey 1997/1998 | | |
| Alcohol consumption | How often do you have an alcoholic drink of any kind? | NSW health survey 1997/1998 | | |
| Amount of alcohol consumption | On a day that you have alcoholic drinks, how many standard drinks do you have> | NSW health survey 1997/1998 | Modified | To ensure example of a ‘standard drink’ is equivalent to State/Territory terminology |

The primary data sources for the Client Information Questionnaire were:

| | |
|---|---|
| • Census 2001 | See ABS publication 2901.0 *Census dictionary* www.abs.gov.au |
| • National Health Survey 2001<br>• National Health Survey – Women's supplementary Health Form 2001 | See ABS publication 4364.0 *National Health Survey: Users' Guide* for detailed information about the survey www.abs.gov.au |
| • NSW health survey 1997/1998 | See the New South Wales Health web site for further details on this survey (www.health.nsw.gov.au) |
| • HACC minimum data set 1998<br>• | See the guidelines to the HACC MDS and HACC Data Dictionary v 1.0 1998 for further details concerning this data set http://www.health.gov.au/internet/wcms/publishing.nsf/Content/hacc-pub_mds_gdd.htm-copy2 |
| • National Health Data Dictionary | See Australian Institute of Health and Welfare publication AIHW Catalogue Number HWI 30 *National Health Data Dictionary Version 10* for more details |

# Appendix 12

# Non-Indigenous Client Information Questionnaire

# CLIENT INFORMATION QUESTIONNAIRE

Office Use Only

1. Are you male or female?
   *Please tick **one** box.*

   Male ……..……...…….... ☐ — 1

   Female ……..…..…..... ☐ — 2

2. What is your date of birth?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| ***D*** | ***D*** | ***M*** | ***M*** | | | | |
| ***Y*** | ***Y*** | ***Y*** | ***Y*** | | | | |

**Office Use only:**

Identification number: | | | | | | |

Date of recruitment: | | | | | | | | |
*D D M M Y Y Y Y*

Date of questionnaire completion: | | | | | | | | |
*D D M M Y Y Y Y*

Administration point:
(tick appropriate box)

Baseline ……. ☐

Six months ….……..... ☐

Eighteen months or end of project ……..… ☐

Client Residential Postcode: | | | | |

Region: | |

3. In which country were you born?

*Please tick **one** box.*

| | | Office Use Only |
|---|---|---|
| Australia ……. | ☐ | 1101 |
| England …….. | ☐ | 2102 |
| Scotland ……. | ☐ | 2105 |
| New Zealand …….. | ☐ | 1201 |
| Italy ……. | ☐ | 3104 |
| Greece ……. | ☐ | 3207 |
| Croatia …… | ☐ | 3204 |
| Lebanon …….. | ☐ | 4206 |
| Saudi Arabia ……... | ☐ | 4209 |
| China……... | ☐ | 6101 |
| Viet Nam …… | ☐ | 5105 |
| Other ……...… | ☐ | #### |

*Specify:*

_____

4. Do you speak a language other than English *at home*?

*Please tick **one** box.*

| | | |
|---|---|---|
| No, English Only ……..……..…. | ☐ | 1201 |
| Yes, Italian …….. | ☐ | 2401 |
| Yes, Greek …….. | ☐ | 2201 |
| Yes, Cantonese ……... | ☐ | 7101 |
| Yes, Mandarin …… | ☐ | 7104 |
| Yes, Arabic ……. | ☐ | 4202 |
| Yes, Lebanese ……. | ☐ | 4202 |
| Yes, Vietnamese ……. | ☐ | 1301 |
| Yes, Creole ……. | ☐ | 9400 |
| Yes, Gruinji …… | ☐ | 9800 |
| Yes, Other …….…….. | ☐ | #### |

*Specify:* _____

5. Are you of Aboriginal or Torres Strait Islander origin?
*Please tick **one** box.*

Office Use Only

| | | |
|---|---|---|
| Yes ……..……...…… | ☐ | 1 |
| No ……..…… | ☐ | 2 |

6. What is your present marital status?
*Please tick **one** box.*

| | | |
|---|---|---|
| Never married ……..…..…… | ☐ | 1 |
| Widowed ……..……. | ☐ | 2 |
| Divorced ……... | ☐ | 3 |
| Separated but not divorced ……... | ☐ | 4 |
| Married (including de facto)…….. | ☐ | 5 |

7. If you are female, how many babies have you ever had?

*(Include live births only).*

If you have had no babies, simply write '0'.

☐ ##

8. What is the highest level of primary or secondary school you have completed?

*Please tick **one** box.*

If you have returned after a break to complete your schooling, tick the highest level completed when you last left.

| | | |
|---|---|---|
| Still at school ……..……..…..…... | ☐ | 1 |
| Did not go to school …….……...…. | ☐ | 2 |
| Year 8 or below ……..……...…….…... | ☐ | 3 |
| Year 9 or equivalent ……...…….…. | ☐ | 4 |
| Year 10 or equivalent ……...…….…... | ☐ | 5 |
| Year 11 or equivalent …….……...…... | ☐ | 6 |
| Year 12 or equivalent …….…….. | ☐ | 7 |

Office Use Only

9. What is the highest level of qualification that you have completed? For example, trade certificate, bachelor degree, associate diploma, certificate 2, advanced diploma.

| |
|---|
| |

1
2
3
4
5
6

10. *How would you describe your current employment status*? Are you…
*Please tick **one** box.*

| | | |
|---|---|---|
| Employed full-time ……. | ☐ go to question 11 | 1 |
| Employed part-time ...…….. | ☐ go to question 11 | 2 |
| Unemployed …… | ☐ go to question 13 | 3 |
| Home duties ……..…….. | ☐ go to question 13 | 4 |
| Student and working …… | ☐ go to question 13 | 5 |
| Student and not working ……. | ☐ go to question 13 | 6 |
| Retired …… | ☐ go to question 12 | 7 |

Unable to work due to heath problems …..…. ☐ go to question 13 — 8

Other ……..…….. ☐ go to question 13 — 9

*Specify*: _____

11. If you are employed full or part time, what is your occupation?

| | | |
|---|---|---|
| | Go to question 13 | ### |

12. If you are retired, what *was* your *main* occupation? That is, the main occupation that you previously spent most time doing.

| | | |
|---|---|---|
| | Go to question 13 | ### |

13. Do you currently receive income from any of these sources?
*Please tick the **appropriate** box/es.*

Office Use Only

| | | |
|---|---|---|
| Wages and salary ……..…... | ☐ | 1, 2 |
| Government pension or allowance ……..… | ☐ | 1, 2 |
| Child support or maintenance …….…… | ☐ | 1, 2 |
| Superannuation or annuity …….……. | ☐ | 1, 2 |
| Any other regular source …….……... | ☐ | 1, 2 |
| *Specify*: _____ | | |
| No/none of the above …….…. | ☐ | 1, 2 |

14. Do you currently receive any of these pensions, allowances or benefits? Answering this question is **OPTIONAL.**

Please select the pension type which is ***most important*** to you.
*Please tick **one** box.*

| | | |
|---|---|---|
| Australian Age Pension ……..……..…... | ☐ | 01 |
| Newstart Allowances …….……..… | ☐ | 02 |
| Mature Age Allowance ……..…….…… | ☐ | 03 |
| Service Pension (DVA) …….……. | ☐ | 04 |
| Disability Support Pension (Centrelink) ……. | ☐ | 05 |
| Wife Pension ……... | ☐ | 06 |
| Carer Pension …….. | ☐ | 07 |
| Sickness Allowance …… | ☐ | 08 |
| Widow Allowance (Widow B Pension) (Centrelink) ……. | ☐ | 09 |
| Special Benefit …… | ☐ | 10 |
| Partner Allowance. ……. | ☐ | 11 |
| Youth Allowance …… | ☐ | 12 |
| No/none of the above ……. | ☐ | 13 |

Office Use Only

15. What are your current living arrangements?
*Please tick **one** box.*

| | | |
|---|---|---|
| I live alone ……...……. | ☐ | 1 |
| I live with family ….……...…….. | ☐ | 2 |
| I live with others …….…..…… | ☐ | 3 |

16. Which of the following best describes the setting in which you live?
*Please tick **one** box.*

| | | |
|---|---|---|
| Private residence (e.g. owning/purchasing, public/private rental) ……....….. | ☐ | 1 |
| Partially supported living (e.g. independent living unit within a retirement village) …..…... | ☐ | 2 |
| Fully supported living (e.g. short term crisis facility, hostels for people with disabilities)… | ☐ | 3 |
| Temporary shelter …….……..……..….. | ☐ | 4 |
| Other ……...……. | ☐ | 5 |

*Specify*: _____

*A carer is a person who may be a family member, friend, relative or other who **regularly** helps you **formally or informally** with managing your life.*

17. Which of the following, best describes your situation?
*Please tick **one** box.*

| | | |
|---|---|---|
| I have a carer……. | ☐ go to question 18 | 1 |
| I do not have a carer …….……..….. | ☐ go to question 19 | 2 |

18. If you have a carer, which of the following best describes them …
*Please tick **one** box.*

| | | |
|---|---|---|
| My carer lives with me ……...……. | ☐ | 1 |
| My carer does not live with me …….…... | ☐ | 2 |

19. Indicate below which chronic condition(s) you have and the ***number of years*** you have had the condition.
*Please tick the **appropriate** box/es**.***

Office Use Only

**Number of years**

**Diabetes**: ……..……..…… ☐ ☐ 1, 2

*Specify* _____ (e.g. Type 1 or 2 diabetes)

**Arthritis or other joint/bone condition**: ……. ☐ ☐ 1, 2

*Specify* _____

**Chronic respiratory/lung condition**: ……..☐ ☐ 1, 2

*Specify* _____

**Cardiovascular disease (including stroke, high blood pressure and angina)**: ……..……..……...……. ☐ ☐ 1, 2

*Specify* _____

**Renal Disease**: ……...…… ☐ ☐ 1, 2

*Specify* _____

**Depression**: …… ☐ ☐ 1, 2

**Osteoporosis:** ……..…… ☐ ☐ 1, 2

**Other chronic condition**: ……...……..…….. ☐ ☐ 1, 2

*Specify:* _____

20. Which **one** of these conditions impacts most heavily upon your day-to-day activities?

☐ 1
2
3
4
5
6
7
8

Office Use Only

21. Which of the following best describes your smoking status?
*Please tick **one** box.*

| | | |
|---|---|---|
| I smoke daily …….. | ☐ | 1 |
| I smoke occasionally …….. | ☐ | 2 |
| I don't smoke now, but I used to ……... | ☐ | 3 |
| I have tried it a few times, but never smoked regularly …….….. | ☐ | 4 |
| I have never smoked …….. | ☐ | 5 |

22. How often do you have an alcoholic drink of any kind?
This includes wine, beer and spirits.
*Please tick **one** box.*

| | | |
|---|---|---|
| Every day ……. | ☐ Go to question 23 | 01 |
| 6 days a week …….. | ☐ Go to question 23 | 02 |
| 5 days a week …….. | ☐ Go to question 23 | 03 |
| 4 days a week …….. | ☐ Go to question 23 | 04 |
| 3 days a week …….. | ☐ Go to question 23 | 05 |
| 2 days a week …….. | ☐ Go to question 23 | 06 |
| 1 day a week …… | ☐ Go to question 23 | 07 |
| Fortnightly or less …… | ☐ Go to question 23 | 08 |
| Monthly or less …… | ☐ Go to question 23 | 09 |
| I don't drink alcohol …… | ☐ Thank you | 10 |

***Alcoholic drinks are measured in terms of a 'standard drink'.***

Office Use Only

23. On a day that you have alcoholic drinks, how many standard drinks do you have?

***A standard drink is equal to:***

| | |
|---|---|
| **1** | *[Insert appropriate State/Territory measurement]*, ***OR*** |
| **1** | *[Insert appropriate State/Territory measurement]*, ***OR*** |
| **1** | *[Insert appropriate State/Territory measurement]*, ***OR*** |
| **1** | *[Insert appropriate State/Territory measurement]* |

*Please tick **one** box.*

| | | |
|---|---|---|
| 1 drink ……...……...……..…. | ☐ | 01 |
| 2 drinks ……..... | ☐ | 02 |
| 3 to 4 drinks. ……..... | ☐ | 03 |
| 5 drinks …….…….…….. | ☐ | 04 |
| 6 drinks……..…….……....…. | ☐ | 05 |
| 7 to 8 drinks ……....……..….. | ☐ | 06 |
| 9 to 12 drinks ……...…….……... | ☐ | 07 |
| 13 drinks or more …….…….... | ☐ | 08 |

**Thank you again for taking the time to complete this questionnaire**

# Appendix 13

# Background Information and Rationale for the Stanford 2000

Background information and rationale for Stanford 2000

| Stanford - Health Assessment Questionnaire 2000 version | |
|---|---|
| **Description of the measure** | Multi-component: measures participants 1 general health - SF1; 2 symptoms (12 items including health distress symptoms, pain, shortness of breath, fatigue – 3 VAS); 3 physical activity level (6 items); 4 coping with symptoms (6 items); 5 physical abilities (8 items; optional: same questions with use of aids/devices and help from another person); 6 Intrusiveness of illness into life (13 items); 7 confidence about doing things (6 items); 8 daily activities (4 items);* |
| **Reliability/validity** | Disability index and pain scale reliable and valid in different languages and contexts |
| **Responsiveness (Sensitivity to change)** | Disability Index and Pain scale sensitive to change in numerous observational studies and clinical trials. |
| **Administration recommended** | Usually self-administered but can also be administered (face-to face or telephone interviews). |
| **Time to complete** | About 10 mins (5 mins for Disability Index and Pain scale) |
| **Number of items** | 56 items without medical care and demos questions |
| **Population norms/comparisons** | Disability Index and Pain scale components have been extensively used since 1980 in experimental conditions and clinical settings, with various chronic conditions, with clients from various SES, translated in several languages. |
| **Previous use in elderly/ people with chronic & complex needs** | Lorig et al have developed the above scales and validated them in short or long forms with chronic patients - lung disease, CVD, Diabetes, stroke, heart failure, HIV and arthritis; |
| **Previous use in Australian setting** | Unknown |
| **Comments** | Keep bars rather than straight line for VAS. |

**References**

Lorig K, et al. Effect of a self-management program on patients with Chronic disease. Effective Clinical Practice 2001;4:256-62

Lorig K, Stewart A et al. Outcomes Measures for Health Education and other health care interventions, 1996; Sage Publications

McDowell I, Newell C. Measuring health; a guide to rating scale and questionnaires, Oxford, 1996

Ramey DR, Raynauld JP, Fries JF. The Health Assessment Questionnaire 1992- Status and Review

# Appendix 14

# Background Information and Rationale for the Kessler 10

**Background information and rationale for Kessler 10**

| KESSLER 10 | |
|---|---|
| **Outcome to be assessed** | 'Psychosocial distress' |
| **Reliability** | N/A |
| **Validity** | It has been validated against concurrent diagnostic data in the Australian National Survey of Mental Health & Wellbeing (Unpublished) |
| **Responsiveness** | N/A |
| **Administration recommended** | Self-administration or via telephone |
| **Time to complete** | 5 minutes |
| **Number of items** | 10 items (4 additional items can be added to asses effect on day to day activities) |
| **Population Norms/Comparisons** | Population norms available for Australian, NSW & US populations. |
| **Previous use in elderly/ people with chronic & complex needs** | Used across a wide range of ages including the elderly. |
| **Previous use in Australian setting** | Used in the 1997 & 1998 NSW Health Surveys. Currently being used in the Victorian Primary Care Partnership & the NSW MH-OAT Project. |
| **Description of the measure** | The Kessler –10 (K10) is a 10-item questionnaire intended to yield a global measure of 'psychosocial distress' based on questions about the level of anxiety & depressive symptoms in the most recent four-week period.<br>Following standard conventions for instruments of this type, a score of one standard deviation above the mean (that is, 60) has been found to be a useful level for further comparisons. It classifies about the same proportion of males (11.2 per cent) & females (15.2 per cent) as having high levels of psychological distress as the percentages found to meet diagnostic criteria for anxiety & depression in other population studies.) (Clinical Research Unit for Anxiety & Depression (CRUfAD)) |

# Appendix 15

# Background Information and Rationale for the Satisfaction With Life Scale

Background information and rationale for the Satisfaction with Life scale

| SATISFACTION WITH LIFE SCALE | |
|---|---|
| **Outcome to be assessed** | The Satisfaction With Life Scales (SWLS) is designed to assess a person's global judgement of life satisfaction & measures change in subjective well-being & intervention outcomes. (Pavot & Diener 1993). |
| **Reliability** | The SWLS has shown strong internal reliability. (Diener et al,1985; Pavot et al, 1991;Yardley & Rice , 1991; Magnus et al, 1993) |
| **Validity** | Good convergent validity with other scales & with other types of assessments of subjective well-being (Diener et al, 1985; Pavot et al, 1991). Discriminant validity from emotional well-being measures (Diener et al,1985; Pavot et al. 1991). Both marital status & health have been shown to be correlated with the SWLS (Arrindell et al, 1991). |
| **Responsiveness** | SWLS has demonstrated sensitivity to be useful to detect change in life satisfaction during the course of clinical intervention (Pavot & Diener 1993). Responsiveness to change over time has been demonstrated in studies by (Vitaliano et al;1991;Diener et al, 1991) |
| **Administration recommended** | Self-administered. The SWLS is available in several languages: French, Dutch, Russian, Korean, Hebrew, & Mandarin (cited in Pavot & Diener 1993). |
| **Time to complete** | Three-Five minutes |
| **# of items** | Five items |
| **Population Norms/Comparisons** | Normative data are available for older adults (Pavot & Diener 1993). |
| **Previous use in elderly/ people with chronic & complex needs** | As above |
| **Previous use in Australian setting** | Study conducted with ICI patients in South Western Sydney. |
| **Description of the measure** | The SWLS was developed to assess satisfaction with the respondent's life as a whole. SWLS items are global rather than specific in nature allowing respondents to weight domains of their lives in terms of their own values, in arriving at a global judgement of life satisfaction. |
| **Comments**<br>SWLS gives participants the opportunity to assess satisfaction with life not just linking it with health related quality of life. It is brief, easy to complete & has been used in ill & debilitated patients in the Australian setting. | |

# Appendix 16

# Non-Indigenous Client Health Questionnaire

# CLIENT HEALTH QUESTIONNAIRE

**Office Use only:**

Identification number: ☐☐☐☐☐☐

Sex: ☐
*M or F*

Date of Birth: ☐☐ ☐☐ ☐☐☐☐
*D D M M Y Y Y Y*

Date of recruitment: ☐☐ ☐☐ ☐☐☐☐
*D D M M Y Y Y Y*

Date of questionnaire completion: ☐☐ ☐☐ ☐☐☐☐
*D D M M Y Y Y Y*

Administration point:
(tick appropriate box)

Baseline ……. ☐

Six months ….……..... ☐

Eighteen months or
end of project.…….... ☐

Client Residential Postcode: ☐☐☐☐

Region: ☐

1. ***In general***, would you say your health is:
*Please tick **one** box**.*

Excellent…… ☐ 1

Very Good……. ☐ 2

Good…….. ☐ 3

Fair…… ☐ 4

Poor…….. ☐ 5

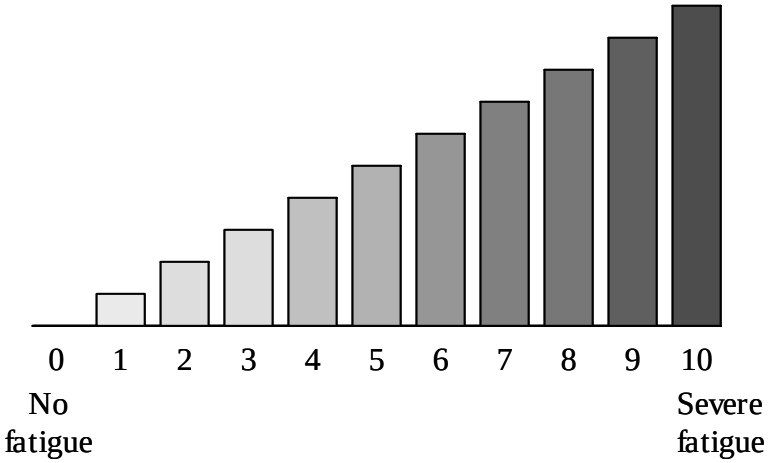
How much time during the ***past 2 weeks***...
*Please tick **one** box for **each** question.*

| | **None of the time** 1 | **A little of the time** 2 | **Some of the time** 3 | **A good bit of the time** 4 | **Most of the time** 5 | **All of the time** 6 |
|---|---|---|---|---|---|---|
| 2. Were you discouraged by your health problems?…….…. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Were you fearful about your future health? ……...…..... | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Was your health a worry in your life? ……..……..……...…… | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Were you frustrated by your health problems? …...……..…… | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |



ID: ☐☐☐☐☐☐

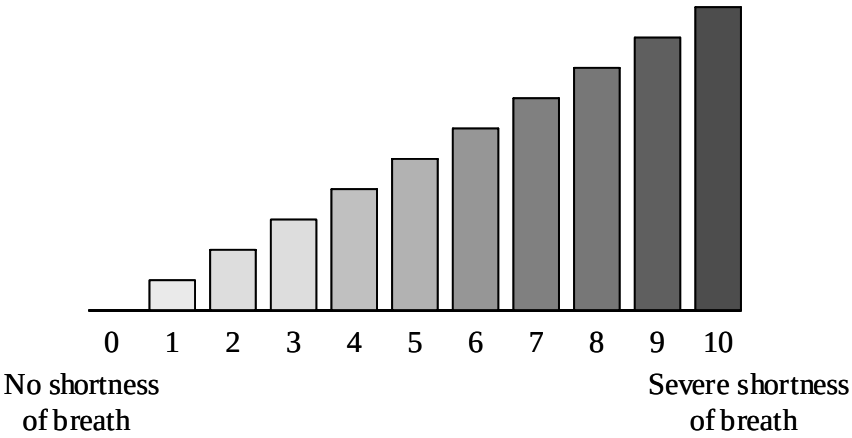
6. We are interested in learning whether or not you are affected by fatigue.
   Please ***circle*** the number below that describes your ***fatigue*** in the ***past 2 weeks***:



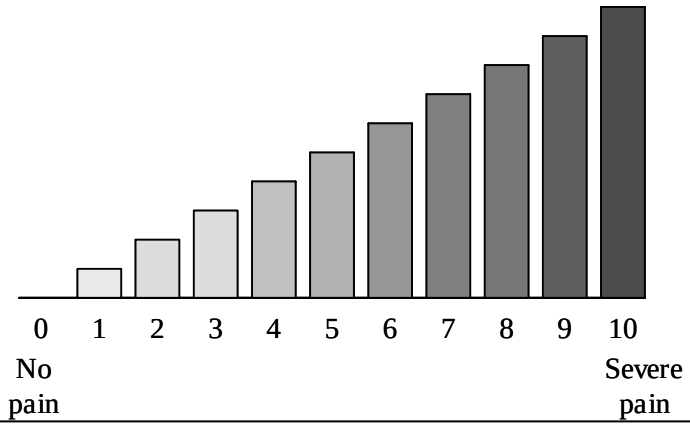



ID: | | | | | | |

7. We are interested in learning whether or not you are affected by shortness of breath. Please ***circle*** the number below that describes your ***shortness of breath*** in the ***past 2 weeks***:




8. We are interested in learning whether or not you are affected by pain.
Please ***circle*** the ***number*** below that describes your ***pain*** in the ***past 2 weeks*:**




***During the past week***, even if it was not a typical week, how much ***total*** time (for the ***entire week***) did you spend on ***each*** of the following?
*Please tick **one** box for **each** question.*

| | | None | Less than 30 mins/wk | 30-60 mins/wk | 1-3 hrs per week | More than 3 hrs/wk |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 9. | Stretching or strengthening exercises (range of motion, using weights, etc.) … | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. | Walk for exercise ……..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. | Swimming or water based activities for exercise ……..……. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. | Bicycling for exercise (including stationary exercise bikes) ……... | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. | Other exercise equipment that made you huff and puff (step machine, rowing machine etc.) …….. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. | Other exercise which made you huff and puff ……. | ☐ | ☐ | ☐ | ☐ | ☐ |

*Specify:* _____



ID: ☐☐☐☐☐☐

When you are feeling down in the dumps, feeling pain or having other unpleasant symptoms, how often do you …
*Please tick **one** box for **each** question.*

| | | Never 1 | Almost never 2 | Some times 3 | Fairly often 4 | Very often 5 | Always 6 |
|---|---|---|---|---|---|---|---|
| 15. | Try to feel distant from the discomfort and pretend that it is not part of your body?……...….. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16. | Don't think of it as discomfort but as some other sensation, like a warm, numb feeling?……..... | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. | Play mental games or sing songs to keep your mind off the discomfort?.... | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18. | Practice progressive muscle relaxation? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19. | Practice visualisation or guided imagery, such as picturing yourself somewhere else?…….……..….. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20. | Talk to yourself in positive ways?…..... | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21. | Do other things to help yourself? ……. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*Specify:*_____

_____

---

***At the moment*, are you able to …**
*Please tick **one** box for **each** question.*

| | | Without any difficulty 1 | With some difficulty 2 | With much difficulty 3 | Unable to do 4 |
|---|---|---|---|---|---|
| 22. | Dress yourself, including tying shoelaces and doing buttons?……..... | ☐ | ☐ | ☐ | ☐ |
| 23. | Get in and out of bed?……... | ☐ | ☐ | ☐ | ☐ |
| 24. | Lift a full cup or glass to your mouth?….. | ☐ | ☐ | ☐ | ☐ |
| 25. | Walk outdoors on flat ground?…….. | ☐ | ☐ | ☐ | ☐ |
| 26. | Wash and dry your entire body?……... | ☐ | ☐ | ☐ | ☐ |
| 27. | Bend down to pick up clothing from the floor? …… | ☐ | ☐ | ☐ | ☐ |
| 28. | Turn taps on and off? ……...…… | ☐ | ☐ | ☐ | ☐ |
| 29. | Get in and out of a car? …… | ☐ | ☐ | ☐ | ☐ |



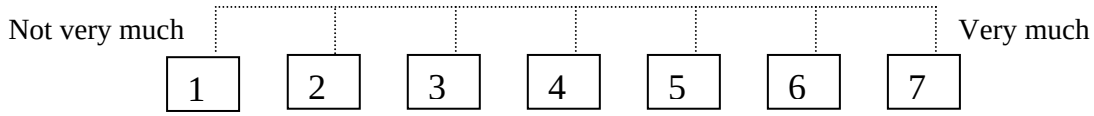
ID: ☐☐☐☐☐☐

The following items ask about how much your condition and/or its treatment interfere with your life. Please mark on the scales below the numbered box that best describes your current life situation.

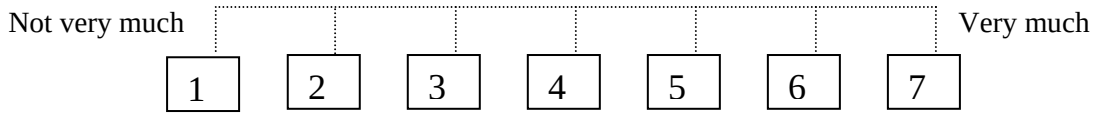
How much does your condition and/or its treatment interfere with:

*Please circle **one** number for **each** question. If an item is not relevant to you, please tick the '**not applicable'** box. Please do not leave any question unanswered.*

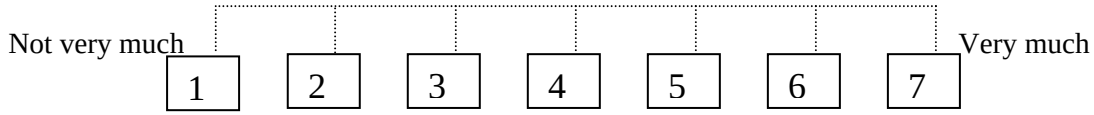
30. Your feeling of being healthy? ☐ Not applicable



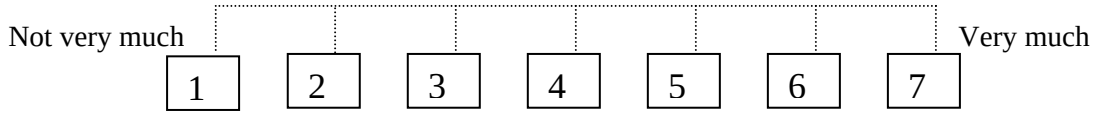

31. The things you eat and drink? ☐ Not applicable



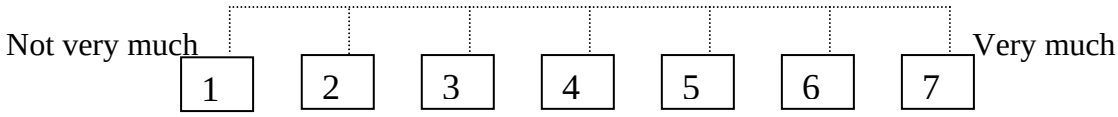

32. Your work, including job, house work, chores, or errands? ☐ Not applicable



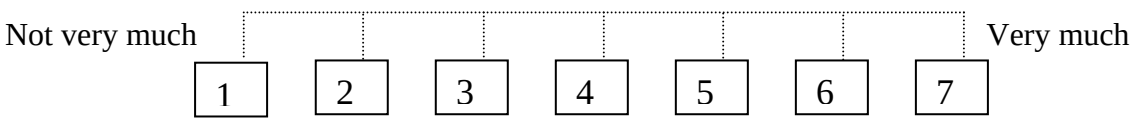

33. Playing sports, gardening, or other physical recreation or hobbies? ☐ Not applicable




34. Quiet recreation or hobbies, such as reading, TV, music, knitting etc.? ☐ Not applicable




35. Your financial situation? ☐ Not applicable

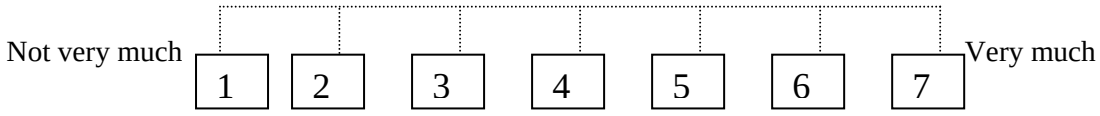




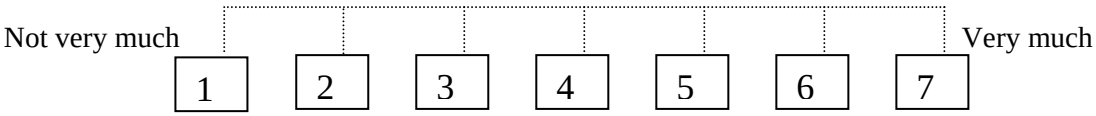

ID: ☐☐☐☐☐☐

How much does your condition and/or its treatment interfere with:

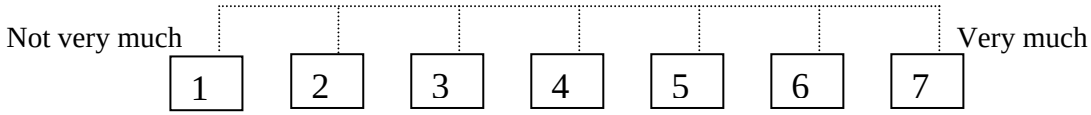
36. Your relationship with your spouse or domestic partner? ☐ Not applicable



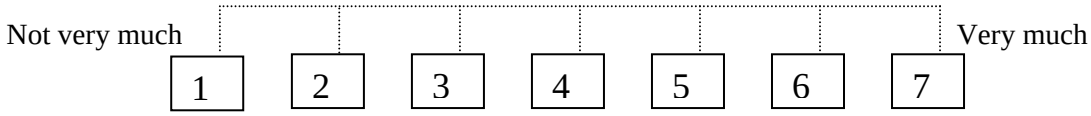

37. Your sex life? ☐ Not applicable



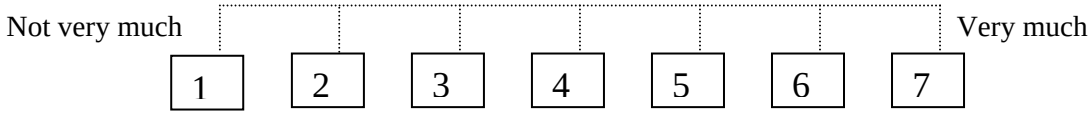

38. Your relationship and social activities with your family? ☐ Not applicable



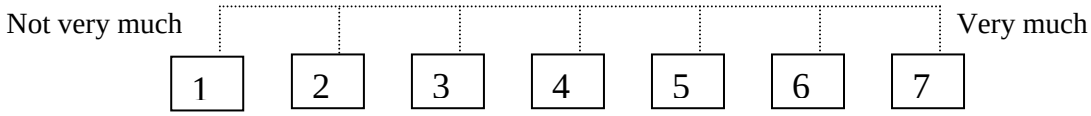

39. Social activities with your friends, neighbours, or groups? ☐ Not applicable



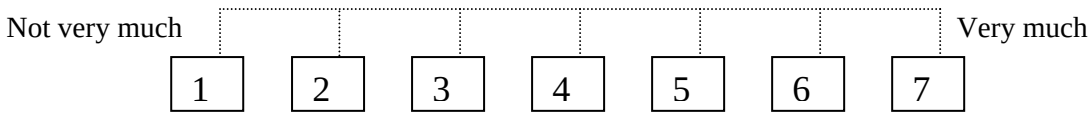

40. Your religious or spiritual activities? ☐ Not applicable




41. Your involvement in community or civic activities? ☐ Not applicable




42. Your self-improvement or self-expression activities? ☐ Not applicable





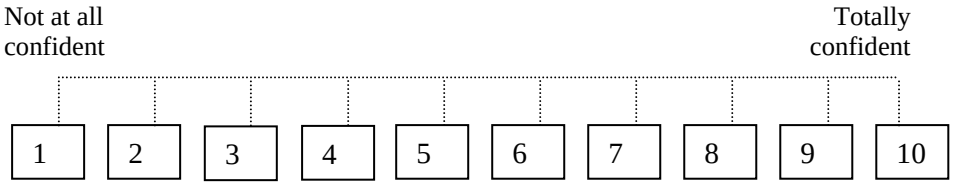

ID: | | | | | | |

You may feel that some of the questions below are not relevant to you. If this is the case, just ask yourself how confident ***would*** you feel in dealing with it if did exist.

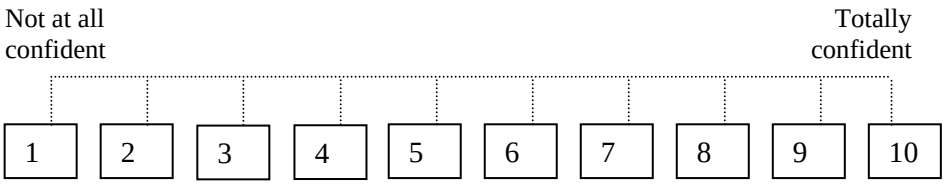
**How confident are you that you can …**

*For **each** of the following questions, please circle the **one** number that corresponds with your **confidence** that you can do the tasks regularly at the present time.*

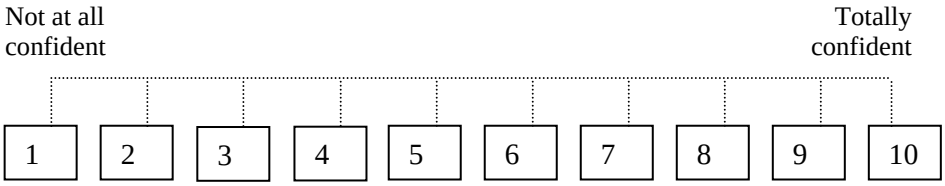
43. Keep the fatigue caused by your condition from interfering with the things you want to do?



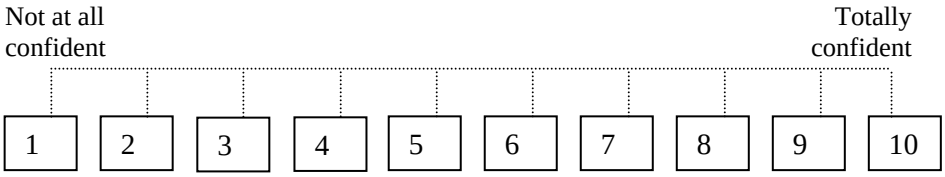

44. Keep the physical discomfort or pain of your condition from interfering with the things you want to do?



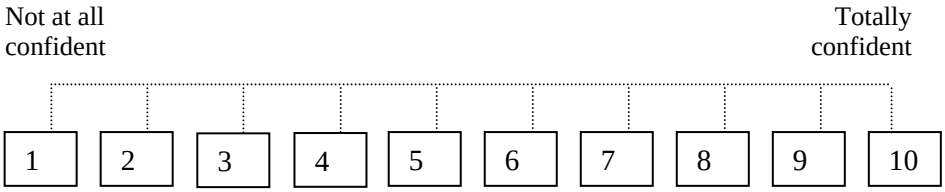

45. Keep the emotional distress caused by your condition from interfering with the things you want to do?



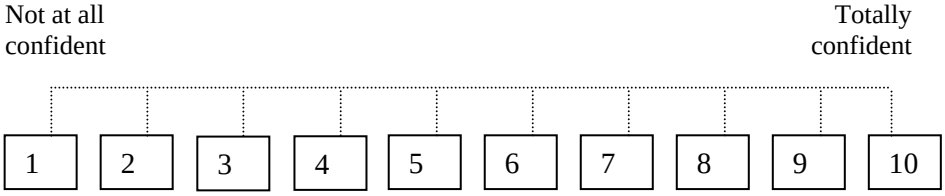

46. Keep any other symptoms or health problems you have from interfering with the things you want to do?




47. Do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?




48. Do things other than just taking medication to reduce how much your condition affects your everyday life?






ID: | | | | | | |

The following questions are about your feelings in the past 4 weeks.

*Please tick **one** box for **each** question.*

| | **All of the time** 1 | **Most of the time** 2 | **Some of the time** 3 | **A little of the time** 4 | **None of the time** 5 |
|---|---|---|---|---|---|
| 49. *In the past 4 weeks*, about how often did you feel tired out for no good reason? …….. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 50. *In the past 4 weeks*, about how often did you feel nervous? ……..…….. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 51. *In the past 4 weeks*, about how often did you feel so nervous that nothing could calm you down? …...…….. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 52. *In the past 4 weeks*, about how often did you feel hopeless? ……... | ☐ | ☐ | ☐ | ☐ | ☐ |
| 53. *In the past 4 weeks*, about how often did you feel restless or fidgety? ……..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| 54. *In the past 4 weeks*, about how often did you feel so restless you could not sit still? ……...…….... | ☐ | ☐ | ☐ | ☐ | ☐ |
| 55. *In the past 4 weeks*, about how often did you feel depressed? ……..….... | ☐ | ☐ | ☐ | ☐ | ☐ |
| 56. *In the past 4 weeks*, about how often did you feel that everything was an effort?..……... | ☐ | ☐ | ☐ | ☐ | ☐ |
| 57. *In the past 4 weeks*, about how often did you feel so sad that nothing could cheer you up? …….. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 58. *In the past 4 weeks*, about how often did you feel worthless? ……..……... | ☐ | ☐ | ☐ | ☐ | ☐ |



ID: ☐☐☐☐☐☐

Below are five statements with which you may agree or disagree. For each statement, tick **one** box to show whether you agree or disagree and how strongly you agree or disagree.

*Please tick **one** box for **each** statement*.

| | **Strongly disagree** 1 | **Disagree** 2 | **Slightly disagree** 3 | **Neither agree or disagree** 4 | **Slightly agree** 5 | **Agree** 6 | **Strongly agree** 7 |
|---|---|---|---|---|---|---|---|
| 59. In most ways my life is close to ideal. ….. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 60. The conditions of my life are excellent. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 61. I am satisfied with my life. …… | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 62. So far I have gotten the important things I want in life. ……... | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 63. If I could live my life over, I would change almost nothing. ……... | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

---

In the past **6 months**, how many times have you seen each of the following providers of health services (please also consider home visits)? *Do not include visits while in hospital or to a hospital emergency room.*
(If you have not visited any of the following, simply write "0").

**Number of Visits**

64. A General Practitioner? …….……...…...…….…… ☐
65. A Specialist? (for example, Cardiologist) ….……... ☐
66. A Practice Nurse or a Community Nurse?……..……... ☐
67. An Aboriginal Health Worker?…….. ☐
68. Another type of health professional? (for example, Podiatrist, Occupational Therapist). …….…….. ☐



ID: ☐☐☐☐☐☐

69. In the past **6 months**, how many times have you been to hospital for **one night or more?**……...……..…..….. (Write "0" if you have not been to hospital). ☐

70. In the past **6 months**, how many times did you go to a hospital accident and emergency or casualty department? . (Write "0" if you have not been to a hospital accident and emergency or casualty department). ☐

71. Are you **currently** receiving help from any community services? (For example, respite care, home help, meals on wheels) …… 1 ☐ **Yes** 2 ☐ **No**

**IF YES**, how often?
*Please tick **one** box.*

| **Less than once a week** | **Once a week** | **2 –3 times a week** | **Daily** | **More than daily** |
|---|---|---|---|---|
| 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ |

Please tell us what these community services are…

Community service 1 _____

Community service 2 _____

Community service 3 _____

72. Are you **currently** going to any self-help / support groups? (For example, Huff and Puff Respiratory Support Group) ……. 1 ☐ **Yes** 2 ☐ **No**

**IF YES**, please tell us what these are…

Self help / support group 1 _____

Self help / support group 2 _____

Self help / support group 3 _____

**IF YES**, how did you find out about these self help / support groups?
*Please tick the **appropriate** boxes.*

| | | |
|---|---|---|
| Friend/Neighbour/Relative ……... | ☐ | 1,2 |
| Health Service Provider …… | ☐ | 1,2 |
| Television/Radio/Newspaper …… | ☐ | 1,2 |
| The Sharing Health Care Initiative …… | ☐ | 1,2 |
| Other ……. | ☐ | 1,2 |

*Specify:* _____



ID: ☐☐☐☐☐☐

**Thank you again for taking the time to complete this questionnaire**

# Appendix 17

# Non-Indigenous Client Service Use Questionnaire

# CLIENT SERVICE USE QUESTIONNAIRE

**Office Use only:**

Identification number: | | | | | | |

Sex: | |
*M or F*

Date of Birth: | | | | | | | | | |
*D D M M Y Y Y Y*

Date of recruitment: | | | | | | | | |
*D D M M Y Y Y Y*

Date of questionnaire completion: | | | | | | | | |
*D D M M Y Y Y Y*

Administration point:

12 Months……. | |

Client Residential Postcode: | | | | |

Region: | |

In the past **6 months**, how many times have you seen each of the following providers of health services (please also consider home visits)? *Do not include visits while in hospital or to a hospital emergency room.*
If you have not visited any of the following, simply write "0".

**Number of Visits**

1. A General Practitioner? …….……...…...…….…… ☐
2. A Specialist? (for example, Cardiologist) ….……... ☐
3. A Practice Nurse or a Community Nurse?..……...……... ☐
4. An Aboriginal Health Worker?…….. ☐
5. Another type of health professional? (for example, Podiatrist, Occupational Therapist, Physiotherapist). …….…….. ☐

6. In the past **6 months**, how many times have you been to hospital for **one night or more?**……...……..…...….... ☐
(write "0" if you have not been to the hospital).

7. In the past **6 months**, how many times did you go to a hospital accident and emergency or casualty department?. ☐
(write "0" if you have not been to a hospital accident and emergency or casualty department).

8. Are you **currently** receiving help from any community services? (For example, respite care, home help, meals on wheels) …… 1 ☐ **Yes** 2 ☐ **No**

**IF YES**, how often?
*Please tick **one** box.*

| **Less than once a week** | **Once a week** | **2 –3 times a week** | **Daily** | **More than daily** |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
| ☐ | ☐ | ☐ | ☐ | ☐ |

Please tell us what these community services are…

Community service 1 _____

Community service 2 _____

Community service 3 _____



ID: ☐☐☐☐☐☐

9. Are you **currently** going to any self-help / support groups? (For example, Huff and Puff Respiratory Support Group) ……..

| | 1 | 2 |
|---|---|---|
| | ☐ **Yes** | ☐ **No** |

**IF YES**, please tell us what these are…

Self help / support group 1 _____

Self help / support group 2 _____

Self help / support group 3 _____

**IF YES**, how did you find out about these self help / support groups?
*Please tick the **appropriate** boxes.*

| | | |
|---|---|---|
| Friend/Neighbour/Relative ……... | ☐ | 1,2 |
| Health Service Provider …… | ☐ | 1,2 |
| Television/Radio/Newspaper …… | ☐ | 1,2 |
| The Sharing Health Care Initiative …… | ☐ | 1,2 |
| Other …….. | ☐ | 1,2 |

*Specify:* _____



ID: | | | | | | |

**Thank you again for taking the time to complete this questionnaire**

# Appendix 18

# Indigenous Client Information Questionnaire – Pika Wiya (SA)

# CLIENT INFORMATION QUESTIONNAIRE

| | Office Use Only |
|---|---|
| 1. Are you male or female?<br>*Please tick **one** box.*<br>Male …….……...…….…... ☐<br>Female ……...…..….... ☐ | <br><br>1<br>2 |
| 2. What is your date of birth?<br>☐☐ ☐☐ ☐☐☐☐<br>***D D M M Y Y Y Y*** | |

**Office Use only:**

Identification number: 9 ☐☐☐☐☐

Date of recruitment: ☐☐ ☐☐ ☐☐☐☐
*D D M M Y Y Y Y*

Date of questionnaire completion: ☐☐ ☐☐ ☐☐☐☐
*D D M M Y Y Y Y*

Administration point:
(tick appropriate box)

Baseline ……. ☐

Six months ….……..... ☐

Eighteen months or end of project ……..… ☐

Client Residential Postcode: ☐☐☐☐

Region: ☐

Office Use Only

3. Do you speak a language other than English *at home*?
*Please tick **one** box.*

Yes ……..……..……... ☐ 1

No ……... ☐ 2

*If Yes, specify:* _____

4. Are you of Aboriginal or Torres Strait Islander origin?
*Please tick **one** box.*

Yes, Aboriginal…….…..……...…… ☐ 1

Yes, Torres Strait Islander…….…… ☐ 2

5. What is your present marital status?
*Please tick **one** box.*

Never married ……..…..…… ☐ 1

Widowed …….……. ☐ 2

Divorced ……... ☐ 3

Separated but not divorced ……... ☐ 4

Married (including de facto)…….. ☐ 5

6. If you are female, how many babies have you ever had?
(Include live births only).

☐ ##

*If you have had no babies, simply write '0'.*



ID: 9 | | | | | |

Office Use Only

7. What is the highest level of primary or secondary school you have completed?

*Please tick **one** box.*

If you have returned after a break to complete your schooling, tick the highest level completed when you last left.

| | | |
|---|---|---|
| Still at school ……..……..…..…... | ☐ | 1 |
| Did not go to school …….……...…. | ☐ | 2 |
| Year 8 or below ……..……...……..... | ☐ | 3 |
| Year 9 or equivalent ……...……..…. | ☐ | 4 |
| Year 10 or equivalent ……...……..... | ☐ | 5 |
| Year 11 or equivalent …….……...….... | ☐ | 6 |
| Year 12 or equivalent …….…….. | ☐ | 7 |

8. What is the highest level of qualification that you have completed? For example, TAFE certificate, trade certificate, bachelor degree, associate diploma, correspondence courses, nursing certificate 2, advanced diploma.

1 2 3 4 5 6

| |
|---|
| |

9. If you are employed full or part time, what is your occupation?

###

| |
|---|
| |

10. If you are retired, what *was* your *main* occupation? That is, the main occupation that you previously spent most time doing.

###

| |
|---|
| |



ID: 9 | | | | | |

11. Do you currently receive any of these sources of income?
Answering this question is **OPTIONAL.**

Office Use Only

Please tick the appropriate boxes.

| | | |
|---|---|---|
| Wages/salary ……. | ☐ | 1,2 |
| Australian Age Pension ……..…….…... | ☐ | 1,2 |
| Newstart Allowances …….……..… | ☐ | 1,2 |
| Mature Age Allowance ……..…….…… | ☐ | 1,2 |
| Service Pension (DVA) …….……. | ☐ | 1,2 |
| Disability Support Pension (Centrelink) ……. | ☐ | 1,2 |
| Wife Pension ……... | ☐ | 1,2 |
| Carer Pension …….. | ☐ | 1,2 |
| Sickness Allowance …… | ☐ | 1,2 |
| Widow Allowance (Widow B Pension) (Centrelink) …….. | ☐ | 1,2 |
| Special Benefit …… | ☐ | 1,2 |
| Partner Allowance. ……. | ☐ | 1,2 |
| Youth Allowance …… | ☐ | 1,2 |
| CDEP payment…… | ☐ | 1,2 |
| No/none of the above ……. | ☐ | 1,2 |

*12.* What are your current living arrangements?
*Please tick **one** box.*

| | | |
|---|---|---|
| I live alone ……...……... | ☐ | 1 |
| I live with family ….……...…… | ☐ | 2 |
| I live with others …….…...…….. | ☐ | 3 |

*A carer is a person who may be a family member, friend, relative or other*



ID: 9 | | | | | |

*who **regularly** helps you **formally or informally** with managing your life.*

Office Use Only

13. Which of the following, best describes your situation?
*Please tick **one** box.*

I have a carer…… ☐ 1

I do not have a carer ……..……..…… ☐ 2

14. Indicate below which chronic condition(s) you have and the ***number of years*** you have had the condition.
*Please tick the **appropriate** box/es.*

**Number of years**

**Diabetes**: ……..……..…… ☐ ☐ 1,2

**Arthritis, or other joint/bone condition**: ……..…..… ☐ ☐ 1,2

*Specify* _____

**Chronic respiratory/lung condition**: …….. ☐ ☐ 1,2

*Specify* _____

**Cardiovascular disease (including stroke, high blood pressure and angina)** ……..……. ☐ ☐ 1,2

*Specify* _____

**Renal Disease**: ……...…… ☐ ☐ 1,2

*Specify* _____

**Depression**: …… ☐ ☐ 1,2

**Osteoporosis:** …..…… ☐ ☐ 1,2

**Other chronic condition**: ……...……..…….. ☐ ☐ 1,2

*Specify:* _____

15. Which condition gives you most trouble?

☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8



ID: 9 | | | | | |

16. Which of the following best describes your smoking status?
*Please tick **one** box.*

Office Use Only

| | | |
|---|---|---|
| I smoke daily …….. | ☐ | 1 |
| I smoke occasionally ……... | ☐ | 2 |
| I don't smoke now, but I used to ……... | ☐ | 3 |
| I have tried it a few times, but never smoked regularly …….. | ☐ | 4 |
| I have never smoked …….. | ☐ | 5 |

17. How often do you have an alcoholic drink of any kind?
This includes wine, beer and spirits.
*Please tick **one** box.*

| | | |
|---|---|---|
| Every day ……. | ☐ Go to question 18 | 01 |
| 6 days a week …….. | ☐ Go to question 18 | 02 |
| 5 days a week …….. | ☐ Go to question 18 | 03 |
| 4 days a week …….. | ☐ Go to question 18 | 04 |
| 3 days a week …….. | ☐ Go to question 18 | 05 |
| 2 days a week …….. | ☐ Go to question 18 | 06 |
| 1 day a week …… | ☐ Go to question 18 | 07 |
| Fortnightly or less …… | ☐ Go to question 18 | 08 |
| Monthly or less …… | ☐ Go to question 18 | 09 |
| I don't drink alcohol …… | ☐ Thank you | 10 |



ID: 9 | | | | | |

***Alcoholic drinks are measured in terms of a 'standard drink'.***

Office Use Only

18. On a day that you have alcoholic drinks, how many standard drinks do you have?

***A standard drink is equal to:***

| | |
|---|---|
| **1** | Schooner of regular beer, ***OR*** |
| **1** | Pint of light beer, ***OR*** |
| **1** | Glass of wine, ***OR*** |
| **1** | Nip of spirits |

*Please tick **one** box.*

| | | |
|---|---|---|
| 1 drink ……...……...……..…. | ☐ | 01 |
| 2 drinks ……..... | ☐ | 02 |
| 3 to 4 drinks. ……..... | ☐ | 03 |
| 5 drinks …….……..…….. | ☐ | 04 |
| 6 drinks……..…….……....…. | ☐ | 05 |
| 7 to 8 drinks …….....……..….. | ☐ | 06 |
| 9 to 12 drinks ……...…….…….... | ☐ | 07 |
| 13 drinks or more …….…….... | ☐ | 08 |



ID: 9 | | | | | |

**Thank you again for taking the time to complete this questionnaire**

# Appendix 19

# Indigenous Client Information Questionnaire – Kalkaringi and Lajamanu (NT)

# FORM 1

# CLIENT INFORMATION QUESTIONNAIRE

**Office use only:**

Identification number: ☐☐☐☐☐☐

Date of recruitment: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Date of questionnaire completion: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Administration point:
(tick appropriate box)

Baseline……☐

Six months……☐

End of project……☐

Community: 2….☐

3….☐

 ID: ☐☐☐☐☐☐

1) Sex ☐ M or F

2) Date of Birth: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Age: ☐☐

3) Do you speak a language other than English at home?

Yes……. ☐

No…….. ☐

4) Are you of Aboriginal or Torres Strait Islander origin?

Yes, Aboriginal…….. ☐

Yes, Torres Strait Islander……. ☐

5) What is your present marital status?

Never married…… ☐

Married…….. ☐

Widowed…… ☐

Single again……... ☐

6) If you are female, how many children have you ever had?

If you have had no babies, simply write '0'. ☐

7) How far did you go at school?

Did not go to school……. ☐

Year 1…… ☐

Year 2…… ☐

Year 3…… ☐

Year 4…… ☐

Year 5…… ☐

Year 6…… ☐

Year 7…… ☐

Year 8…… ☐

Year 9…… ☐

Year 10…… ☐

Year 11…… ☐

Year 12…… ☐

8) What is the highest level of qualification that you have completed?

Trade certificate…. ☐

Tafe certificate….. ☐

Bachelor degree…. ☐

Other: ……

9) If you are employed full time, what is your occupation?

……..

10) If you are retired, what was your main occupation? That is the main occupation that you previously spent most time doing?

……..

11) Do you currently receive any of these sources of income?
Answering this question is **OPTIONAL**.

Wages/Salary…….. ☐

Centrelink payment……. ☐

CDEP…….. ☐

Other income…… ☐

No income…… ☐

12) What are your current living arrangements?

I live alone……. ☐

I live with family…… ☐

I live with a friend…….. ☐

13) Do you have people who really look after you?

I do not have a carer…….. ☐

My carer is:

Mother…….. ☐

Father……. ☐

Sister……. ☐

 ID: ☐☐☐☐☐☐

Brother…… ☐

Daughter…… ☐

Son……. ☐

Wife / husband. ☐

Cousin…… ☐

Uncle…….. ☐

Aunty……. ☐

Grandmother.. ☐

Grandfather… ☐

14) Can you tell me which chronic illnesses you have

I don't know……. ☐

Diabetes……. ☐

Cardiovascular (like high blood pressure, stroke, angina)…… ☐

Renal (kidney) disease……. ☐

15) Which one gives you the most trouble?

……

16) About smoking

I smoke every day…… ☐

I only smoke sometimes…… ☐

I don't smoke now, but I used to…… ☐

I have never smoked…… ☐

 ID: ☐☐☐☐☐☐

17) About chewing tobacco

I chew tobacco every day…… ☐

I only chew tobacco sometimes……. ☐

I don't chew tobacco now, but I used to…… ☐

I have never chewed tobacco……. ☐

18) About drinking

I never drink……..…. ☐

I drink sometimes…… ☐

I drink every day…… ☐

I used to drink, but I don't anymore….. ☐

 ID: ☐☐☐☐☐☐

# CLIENT INFORMATION QUESTIONNAIRE

**Office use only:**

Identification number: ☐☐☐☐☐☐

Date of recruitment: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Date of questionnaire completion: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Administration point:
(tick appropriate box)

Baseline……☐ Community: ☐

Six months……☐

End of project……☐

1) Sex ☐ M or F

2) Date of Birth: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Age: ☐☐

3) Do you speak a language other than English at home?

Yes…….☐

No……..☐

4) Are you of Aboriginal or Torres Strait Islander origin?

Yes, Aboriginal……..☐

Yes, Torres Strait Islander…….☐

5) What is your present marital status?

Never married……☐

Married……..☐

Widowed……☐

Single again……...☐

6) If you are female, how many children have you ever had?

If you have had no babies, simply write '0'. ☐

7) How far did you go at school?

Did not go to school……. ☐

Year 1…… ☐

Year 2…… ☐

Year 3…… ☐

Year 4…… ☐

Year 5…… ☐

Year 6…… ☐

Year 7…… ☐

Year 8…… ☐

Year 9…… ☐

Year 10…… ☐

Year 11…… ☐

Year 12…… ☐

8) What is the highest level of qualification that you have completed?

Trade certificate…. ☐

Tafe certificate….. ☐

Bachelor degree…. ☐

Other: ……

9) If you are employed full time, what is your occupation?

……..

10) If you are retired, what was your main occupation? That is the main occupation that you previously spent most time doing?

……..

11) Do you currently receive any of these sources of income?
Answering this question is **OPTIONAL**.

Wages/Salary…… ☐

Centrelink payment…… ☐

CDEP…… ☐

Other income…… ☐

No income…… ☐

12) What are your current living arrangements?

I live alone…… ☐

I live with family…… ☐

I live with a friend……. ☐

13) Do you have people who really look after you?

I do not have a carer…… ☐

My carer is:

Mother…….. ☐

Father……. ☐

Sister……. ☐

Brother…… ☐

 ID: ☐☐☐☐☐☐

Daughter…… ☐

Son……. ☐

Wife / husband. ☐

Cousin…… ☐

Uncle…….. ☐

Aunty……. ☐

Grandmother.. ☐

Grandfather… ☐

14) Can you tell me which chronic illnesses you have

I don't know……. ☐

Diabetes……. ☐

Cardiovascular (like high blood pressure, stroke, angina)….. ☐

Renal (kidney) disease……. ☐

15) Which one gives you the most trouble?

……

16) About smoking

I smoke every day……. ☐

I only smoke sometimes……. ☐

I don't smoke now, but I used to… ☐

I have never smoked……. ☐

 ID: ☐☐☐☐☐☐

17) About chewing tobacco

I chew tobacco every day…… ☐

I only chew tobacco sometimes……. ☐

I don't chew tobacco now, but I used to…… ☐

I have never chewed tobacco……. ☐

18) About drinking

I never drink……..…. ☐

I drink sometimes…… ☐

I drink every day…… ☐

I used to drink, but I don't anymore….. ☐

 ID: ☐☐☐☐☐☐

# Appendix 20

# Indigenous Client Health Questionnaire – Pika Wiya (SA)

# CLIENT HEALTH QUESTIONNAIRE

**Office Use only:**

Identification number: 9 | | | | | |

Sex: | |

*M or F*

Date of Birth: | | | | | | | | |

*D D M M Y Y Y Y*

Date of recruitment: | | | | | | | |

*D D M M Y Y Y Y*

Date of questionnaire completion: | | | | | | | |

*D D M M Y Y Y Y*

Administration point:
(tick appropriate box)

Baseline ……. ☐

Six months ……..... ☐

Eighteen months or end of project……..... ☐

Client Residential Postcode: | | | | |

Region: | |



ID: 9 | | | | | |

1. ***In general***, do you think your health is:
*Please tick **one** box.*

Excellent…… ☐ 1

Very Good……. ☐ 2

Good…….. ☐ 3

Fair…… ☐ 4

Poor…….. ☐ 5

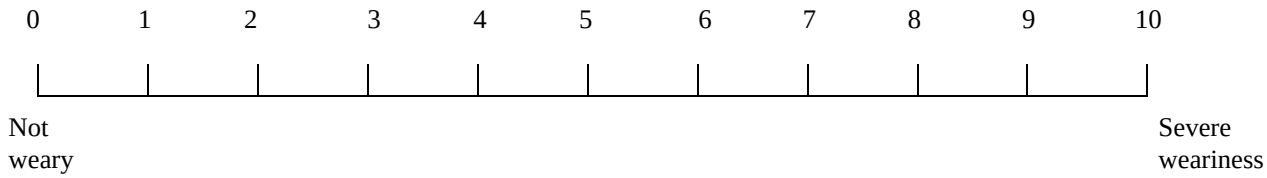
---

***How much*** of the time...
*Please tick **one** box for **each** question.*

| | None of the time 1 | A little of the time 2 | Some of the time 3 | A good bit of the time 4 | Most of the time 5 | All of the time 6 |
|---|---|---|---|---|---|---|
| 2. Are you discouraged by your health problems?…… | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Are you fearful about your future health? ……...…..... | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Is your health a worry in your life? ……..……..……...…… | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Are you frustrated by your health problems? …...……..…… | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

---

6. We are interested in learning whether or not you are affected by tiredness.
Please ***circle*** the number below that describes how ***weary you feel***:

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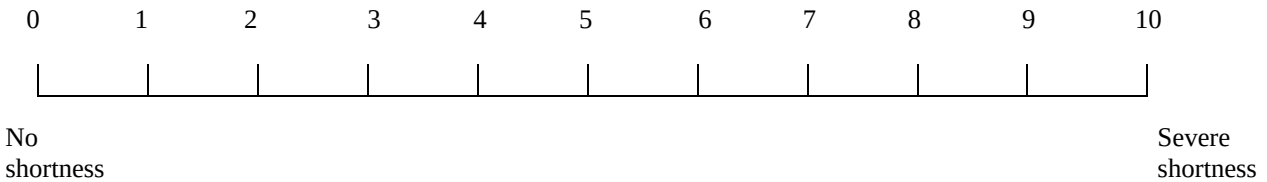
7. We are interested in learning whether or not you are affected by shortness of breath.
Please ***circle*** the number below that describes your ***shortness of breath***:



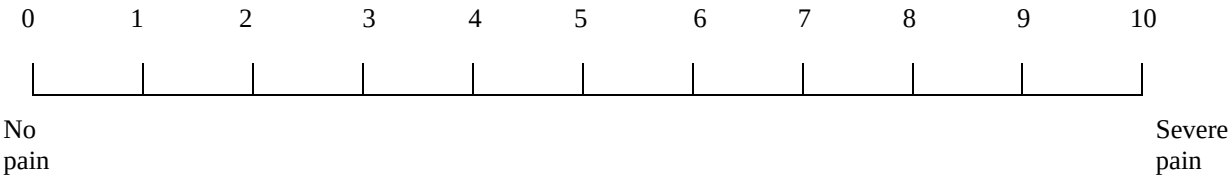

*Specify Cause(s):* _____

_____



ID: 9 | | | | | |

*7.* We are interested in learning whether or not you are affected by pain *anywhere in your body.*
Please ***circle*** the ***number*** below that describes your ***pain*****:**




***How much time*** do you spend on ***each*** of the following?
*Please tick **one** box for **each** question.*

| | | None | Less than 30 mins/wk | 30-60 mins/wk | 1-3 hrs per week | More than 3 hrs/wk |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 9. | Stretching or strengthening exercises (range of motion, using weights, etc.) …… | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. | Walk for exercise ……..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. | Other exercise which makes you huff and puff ……. *Specify:* _____ | ☐ | ☐ | ☐ | ☐ | ☐ |

***At the moment*****,** are you able to …
*Please tick **one** box for **each** question.*

| | | Without any difficulty | With some difficulty | With much difficulty | Unable to do |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 |
| 12. | Dress yourself, including tying shoelaces and doing buttons?……. | ☐ | ☐ | ☐ | ☐ |
| 13. | Get in and out of bed?……..……... | ☐ | ☐ | ☐ | ☐ |
| 14. | Lift a full cup or glass to your mouth?…… | ☐ | ☐ | ☐ | ☐ |
| 15. | Walk outdoors on flat ground?……..……. | ☐ | ☐ | ☐ | ☐ |
| 16. | Wash and dry your entire body?…….…..…….... | ☐ | ☐ | ☐ | ☐ |
| 17. | Bend down to pick up clothing from the floor? ……. | ☐ | ☐ | ☐ | ☐ |
| 18. | Turn taps on and off? ……...……. | ☐ | ☐ | ☐ | ☐ |
| 19. | Get in and out of a car? …… | ☐ | ☐ | ☐ | ☐ |

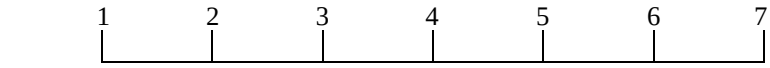


ID: 9 | | | | | |

***How much does your condition and/or its treatment affect**:*

*Please circle **one** number for **each** question. If an item is not relevant to you, please tick the '**not applicable'** box. Please do not leave any question unanswered.*

20. How healthy you feel now? ☐ Not applicable




Not very much — Very much

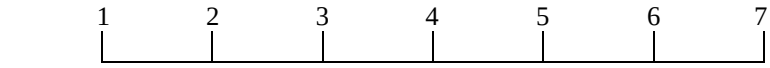
21. The things you eat and drink? ☐ Not applicable


Not very much — Very much

22. Your work, including job, house work, chores, or errands? ☐ Not applicable


Not very much — Very much

23. Playing sports, gardening, or other physical recreation or hobbies? ☐ Not applicable




Not very much — Very much

24. Quiet recreation or hobbies, such as reading, TV, music, knitting etc.? ☐ Not applicable

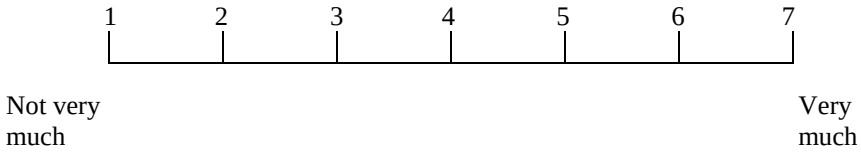

Not very much — Very much



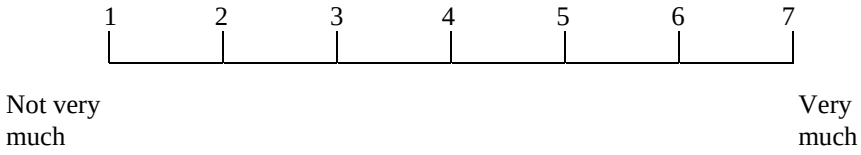
ID: 9 | | | | | |

*How much does your condition and/or its treatment affect:*

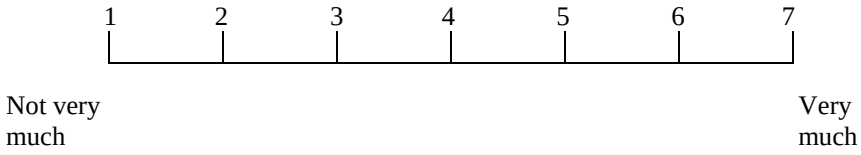
25. Your financial situation? ☐ Not applicable



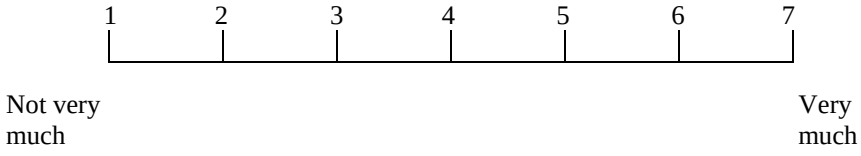

26. Your relationship with your spouse or domestic partner? ☐ Not applicable



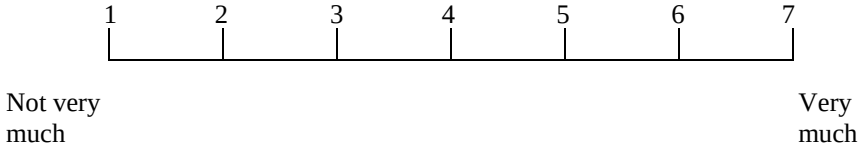

27. Your relationship and social activities with your family? ☐ Not applicable




28. Social activities with your friends, neighbours, or groups? ☐ Not applicable




29. Your religious or spiritual activities? ☐ Not applicable



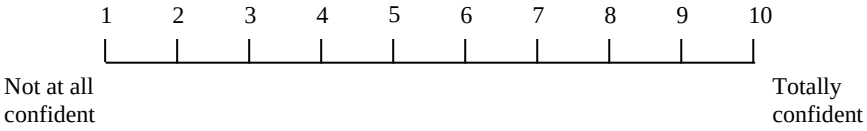



ID: 9 | | | | | |

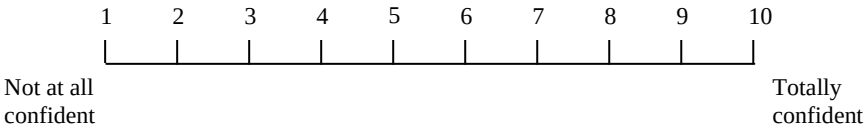
## How confident are you that you can …

Please ***circle*** one number for ***each*** question which matches your ***confidence*** about doing these tasks.

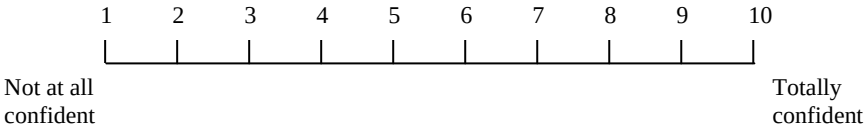
30. Keep the weariness caused by your condition from getting in the way of the things you want to do?



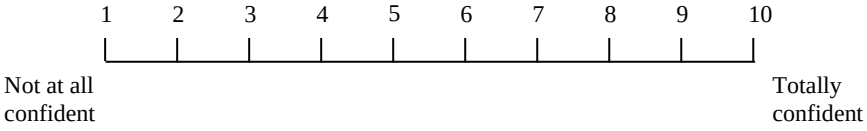

31. Keep the physical discomfort or pain of your condition from getting in the way of the things you want to do?



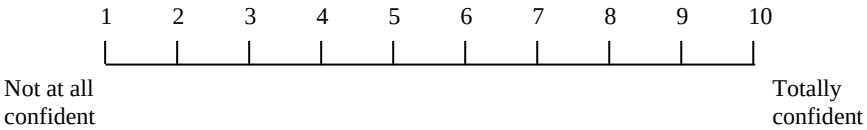

32. Keep the emotional distress (e.g. being angry, down in the dumps, upset) caused by your condition from getting in the way of the things you want to do?



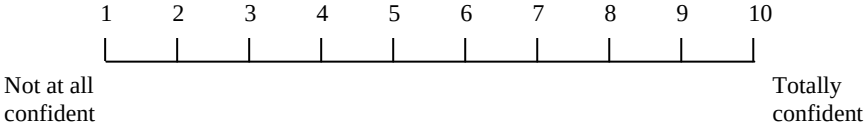

33. Keep any other symptoms or health problems you have from getting in the way of the things you want to do?




34. Do the different tasks and activities (e.g. diet, exercise) needed to manage your health condition so as to reduce your need to see a doctor?




35. Do things other than just taking medication to reduce the effects of your condition on your everyday life (e.g. take bush medicine)?






ID: 9

Thinking about the last **month**, that is since _____[*if helpful, insert appropriate point of reference*], overall how many times did you see each of the following providers of health services (please also consider home visits)? *Do not include visits while in hospital or to a hospital emergency room.*

| | **More than 5 days a week** 1 | **4-5 days a week** 2 | **2-3 days a week** 3 | **About 1 day a week** 4 | **2-3 days a month** 5 | **About 1 day a month** 6 | **Never** 7 |
|---|---|---|---|---|---|---|---|
| 36. A General Practitioner? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 37. A Specialist? (for example, Cardiologist) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 38. A Practice Nurse or a Community Nurse? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 39. An Aboriginal Health Worker? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 40. Another type of health professional? (for example, Podiatrist, Occupational Therapist, Physiotherapist) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

41. In the past **6 months**, how many times have you been to hospital for **one night or more?** (If you have not visited any of the following, simply write "0")…….. ☐

42. In the past **6 months**, how many times did you go to a hospital accident and emergency or casualty department?(If you have not visited any of the following, simply write "0")…... ☐

43. Are you **currently** receiving help from any community services? (For example, respite care, home help, meals on wheels) ……..…… 1 ☐ **Yes** 2 ☐ **No**

**IF YES**, how often?
*Please tick **one** box.*

| **Less than once a week** 1 | **Once a week** 2 | **2 –3 times a week** 3 | **Daily** 4 | **More than daily** 5 |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Please tell us what these community services are…

Community service 1 _____

Community service 2 _____

Community service 3 _____



ID: 9 | | | | | |

44. Are you **currently** going to any self-help / support groups? (For example, Huff and Puff Respiratory Support Group)……..

| 1 | 2 |
|---|---|
| ☐ **Yes** | ☐ **No** |

**IF YES**, please tell us what these are…

Self help / support group 1 _____

Self help / support group 2 _____

Self help / support group 3 _____

**IF YES**, how did you find out about these self help / support groups?
*Please tick the **appropriate** boxes.*

| | | |
|---|---|---|
| Friend/Neighbour/Relative ……... | ☐ | 1,2 |
| Health Service Provider …… | ☐ | 1,2 |
| Television/Radio/Newspaper …… | ☐ | 1,2 |
| The Sharing Health Care Initiative …… | ☐ | 1,2 |
| Other …….. | ☐ | 1,2 |

*Specify:* _____



ID: 9 | | | | | |

**Thank you again for taking the time to complete this questionnaire**