Appendix 11

Development of Client Information Questionnaire data sources
### Client Information Questionnaire – questions and data sources

<table>
<thead>
<tr>
<th>Item</th>
<th>Question</th>
<th>Source</th>
<th>Modified/not modified</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Are you male or female</td>
<td>National health data dictionary ABS 1269.0 1998</td>
<td>Modified</td>
<td>Different phasing of question. Response types same</td>
</tr>
<tr>
<td></td>
<td>Not ‘What is your sex?’</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOB</td>
<td>What is your date of birth</td>
<td>National health data dictionary ABS 1269.0 1998</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COB</td>
<td>In which country were you born</td>
<td>Census 2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>National health data dictionary ABS 1269.0 1998</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language</td>
<td>Do you speak a language other than English at home?</td>
<td>Census 2001</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>National health data dictionary ABS 1269.0 1998</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ATSI</td>
<td>Are you Aboriginal or Torres Strait Islander Origin?</td>
<td>Census 2001</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>ABS 1267.0 1997</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>What is your present marital status</td>
<td>Census 2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of babies</td>
<td>If you are female, how many babies have you had?</td>
<td>National Health Survey – Women’s supplementary Health Form 2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schooling</td>
<td>What is your highest level of primary or secondary school you have completed?</td>
<td>Census 2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Question</td>
<td>Source</td>
<td>Modified/not modified</td>
<td>Comment</td>
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<tr>
<td>--------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Qualification</td>
<td>What is your highest level of qualification that you have completed?</td>
<td>Census 2001</td>
<td></td>
<td></td>
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<tr>
<td>Employment</td>
<td>How would you describe your current employment status</td>
<td>NSW health survey 1997/1998</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td>If you are employed full or part time, what is your occupation</td>
<td>National evaluator</td>
<td></td>
<td>Different phasing of question. Response types same</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coded using ABS 122.0 1997)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retired occupation</td>
<td>If you are retired, what was your main occupation? Than is the main occupation that you previously spent most time doing.</td>
<td>National evaluator</td>
<td></td>
<td>Different phasing of question. Response types same</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coded using ABS 122.0 1997)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income sources</td>
<td>Do you receive income from any of these sources?</td>
<td>National Health data dictionary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pension types</td>
<td>Do you currently receive any of these pensions, allowances or benefits?</td>
<td>National Health Survey 2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living arrangements</td>
<td>What are your current living arrangements?</td>
<td>HACC minimum data set 1998</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation setting</td>
<td>Which of the following best describes the setting in which you live?</td>
<td>HACC minimum data set 1998</td>
<td>Modified</td>
<td>Question same Response types grouped</td>
</tr>
<tr>
<td>Item</td>
<td>Question</td>
<td>Source</td>
<td>Modified/not modified</td>
<td>Comment</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Carer availability</td>
<td>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.</td>
<td>HACC minimum data set 1998</td>
<td>Modified</td>
<td>Different phasing of question.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Response types same</td>
</tr>
<tr>
<td>Carer residence</td>
<td>If you have a carer, which of the following best describes them?</td>
<td>HACC minimum data set 1998</td>
<td>Modified</td>
<td>Different phasing of question.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Response types same</td>
</tr>
<tr>
<td>Smoking</td>
<td>Which of the following best describes your smoking status?</td>
<td>NSW health survey 1997/1998</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>How often do you have an alcoholic drink of any kind?</td>
<td>NSW health survey 1997/1998</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of alcohol consumption</td>
<td>On a day that you have alcoholic drinks, how many standard drinks do you have?</td>
<td>NSW health survey 1997/1998</td>
<td>Modified</td>
<td>To ensure example of a ‘standard drink’ is equivalent to State/Territory terminology</td>
</tr>
</tbody>
</table>
The primary data sources for the Client Information Questionnaire were:

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Source Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Data Dictionary</td>
<td>See Australian Institute of Health and Welfare publication AIHW Catalogue Number HWI 30 <em>National Health Data Dictionary Version 10</em> for more details</td>
</tr>
</tbody>
</table>
Appendix 12

Non-Indigenous Client Information Questionnaire
CLIENT INFORMATION QUESTIONNAIRE

1. Are you male or female?
   Please tick one box.
   Male ........................................... □
   Female ....................................... □

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.*

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

Yes ..................................................  □

No .................................................. □

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

Never married .................................  □

Widowed .................................  □

Divorced .................................  □

Separated but not divorced .................................  □

Married (including de facto).................................  □

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 .................................................. [ ]
- Did not go to school ......................................... [ ]
- Year 8 or below ................................................ [ ]
- Year 9 or equivalent ........................................ [ ]
- Year 10 or equivalent ...................................... [ ]
- Year 11 or equivalent ...................................... [ ]
- Year 12 or equivalent ...................................... [ ]

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

10. *How would you describe your current employment status?* Are you…

*Please tick one box.*

- Employed full-time ........................................ [ go to question 11]
- Employed part-time ....................................... [ go to question 11]
- Unemployed ................................................... [ go to question 13]
- Home duties .................................................. [ go to question 13]
- Student and working ...................................... [ go to question 13]
- Student and not working ................................ [ go to question 13]
- Retired ......................................................... [ go to question 12]
Unable to work due to heath problems .......  ☐  go to question 13

Other ......................................................  ☐  go to question 13

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.*

- Wages and salary .......................... □
- Government pension or allowance ........ □
- Child support or maintenance ............ □
- Superannuation or annuity ............... □
- Any other regular source .................... □
  **Specify:** ______________________________
- No/none of the above ........................ □

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 .................. □
- Newstart Allowances ..................... □
- Mature Age Allowance ................... □
- Service Pension (DVA) .................... □
- Disability Support Pension (Centrelink)  □
- Wife Pension ............................... □
- Carer Pension ............................. □
- Sickness Allowance ...................... □
- Widow Allowance (Widow B Pension) (Centrelink) □
- Special Benefit ........................... □
- Partner Allowance ........................ □
- Youth Allowance ........................... □
- No/none of the above ........................ □
15. **What are your current living arrangements?**  
*Please tick one box.*

- I live alone ........................................... □
- I live with family ................................. □
- I live with others ................................. □

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) ................................. □
- Partially supported living (e.g. independent living unit within a retirement village) ........ □
- Fully supported living (e.g. short term crisis facility, hostels for people with disabilities)… □
- Temporary shelter ........................................ □
- Other ........................................................... □

*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
- I do not have a carer .............................. □ go to question 19

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

- My carer lives with me .............................. □
- My carer does not live with me .................. □
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.*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of years</th>
<th>1, 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify ___________________________ (e.g. Type 1 or 2 diabetes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis or other joint/bone condition:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify _______________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic respiratory/lung condition:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify _______________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular disease (including stroke, high blood pressure and angina):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify _______________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal Disease:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify _______________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression:</td>
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<td></td>
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<tr>
<td>Specify _______________________________</td>
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<td></td>
</tr>
<tr>
<td>Osteoporosis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify _______________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other chronic condition:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify: _____________________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

   _____________________________________________
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’.

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

A standard drink is equal to:

<table>
<thead>
<tr>
<th></th>
<th>[Insert appropriate State/Territory measurement], OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
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<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Please tick one box.

1 drink .................................................... □
2 drinks .................................................... □
3 to 4 drinks .............................................. □
5 drinks ..................................................... □
6 drinks ..................................................... □
7 to 8 drinks .............................................. □
9 to 12 drinks .......................................... □
13 drinks or more ....................................... □
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

<table>
<thead>
<tr>
<th><strong>Stanford - Health Assessment Questionnaire 2000 version</strong></th>
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<tbody>
<tr>
<td><strong>Description of the measure</strong></td>
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<tr>
<td><strong>Reliability/validity</strong></td>
</tr>
<tr>
<td><strong>Responsiveness (Sensitivity to change)</strong></td>
</tr>
<tr>
<td><strong>Administration recommended</strong></td>
</tr>
<tr>
<td><strong>Time to complete</strong></td>
</tr>
<tr>
<td><strong>Number of items</strong></td>
</tr>
<tr>
<td><strong>Population norms/comparisons</strong></td>
</tr>
<tr>
<td><strong>Previous use in elderly/ people with chronic &amp; complex needs</strong></td>
</tr>
<tr>
<td><strong>Previous use in Australian setting</strong></td>
</tr>
<tr>
<td><strong>Comments</strong></td>
</tr>
</tbody>
</table>

**References**


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

<table>
<thead>
<tr>
<th><strong>KESSLER 10</strong></th>
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<tbody>
<tr>
<td><strong>Outcome to be assessed</strong></td>
</tr>
<tr>
<td><strong>Reliability</strong></td>
</tr>
<tr>
<td><strong>Validity</strong></td>
</tr>
<tr>
<td><strong>Responsiveness</strong></td>
</tr>
<tr>
<td><strong>Administration recommended</strong></td>
</tr>
<tr>
<td><strong>Time to complete</strong></td>
</tr>
<tr>
<td><strong>Number of items</strong></td>
</tr>
<tr>
<td><strong>Population Norms/Comparisons</strong></td>
</tr>
<tr>
<td><strong>Previous use in elderly/people with chronic &amp; complex needs</strong></td>
</tr>
<tr>
<td><strong>Previous use in Australian setting</strong></td>
</tr>
<tr>
<td><strong>Description of the measure</strong></td>
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</table>
Appendix 15

Background Information and Rationale for the Satisfaction With Life Scale
### Background information and rationale for the Satisfaction with Life scale

<table>
<thead>
<tr>
<th>SATISFACTION WITH LIFE SCALE</th>
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<td><strong>Outcome to be assessed</strong></td>
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<tr>
<td><strong>Reliability</strong></td>
</tr>
<tr>
<td><strong>Validity</strong></td>
</tr>
<tr>
<td><strong>Responsiveness</strong></td>
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<tr>
<td><strong>Administration recommended</strong></td>
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<tr>
<td><strong>Time to complete</strong></td>
</tr>
<tr>
<td><strong># of items</strong></td>
</tr>
<tr>
<td><strong>Population Norms/Comparisons</strong></td>
</tr>
<tr>
<td><strong>Previous use in elderly/ people with chronic &amp; complex needs</strong></td>
</tr>
<tr>
<td><strong>Previous use in Australian setting</strong></td>
</tr>
<tr>
<td><strong>Description of the measure</strong></td>
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<tr>
<td><strong>Comments</strong></td>
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Appendix 16

Non-Indigenous Client Health Questionnaire
# CLIENT HEALTH QUESTIONNAIRE

**Office Use only:**

- Identification number: 

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<tr>
<th></th>
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- Sex: 

<table>
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<th>M</th>
<th>F</th>
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</table>

- Date of Birth: 

<table>
<thead>
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<th>M</th>
<th>Y</th>
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- Date of recruitment: 

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- Date of questionnaire completion: 

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**Administration point:**

- (tick appropriate box)

<table>
<thead>
<tr>
<th>Baseline ..................</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six months ..............</td>
</tr>
<tr>
<td>Eighteen months or end of project........</td>
</tr>
</tbody>
</table>

- Client Residential Postcode: 

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
</table>

- Region: 

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
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.*

<table>
<thead>
<tr>
<th></th>
<th>None of the time 1</th>
<th>A little of the time 2</th>
<th>Some of the time 3</th>
<th>A good bit of the time 4</th>
<th>Most of the time 5</th>
<th>All of the time 6</th>
</tr>
</thead>
</table>

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? …………………… □ □ □ □ □ □ □
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*:
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:

![Shortness of Breath Scale]

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:

![Pain Scale]

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.

<table>
<thead>
<tr>
<th>Exercise</th>
<th>None</th>
<th>Less than 30 mins/wk</th>
<th>30-60 mins/wk</th>
<th>1-3 hrs per week</th>
<th>More than 3 hrs/wk</th>
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</thead>
<tbody>
<tr>
<td>Stretching or strengthening exercises</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Walk for exercise</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Swimming or water based activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bicycling for exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other exercise equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.*

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

Specify: ________________________________

---

*At the moment, are you able to …

*Please tick one box for each question.*

<table>
<thead>
<tr>
<th>Question</th>
<th>Without any difficulty 1</th>
<th>With some difficulty 2</th>
<th>With much difficulty 3</th>
<th>Unable to do 4</th>
</tr>
</thead>
</table>
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

Not very much  □  1  2  3  4  5  6  7  Very much

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

Not very much  □  1  2  3  4  5  6  7  Very much

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

Not very much  □  1  2  3  4  5  6  7  Very much

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

Not very much  □  1  2  3  4  5  6  7  Very much

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

Not very much  □  1  2  3  4  5  6  7  Very much

35. Your financial situation?  □  Not applicable

Not very much  □  1  2  3  4  5  6  7  Very much
How much does your condition and/or its treatment interfere with:

36. Your relationship with your spouse or domestic partner?  
   - Not applicable  
   - Not very much  
   - Very much

37. Your sex life?  
   - Not applicable  
   - Not very much  
   - Very much

38. Your relationship and social activities with your family?  
   - Not applicable  
   - Not very much  
   - Very much

39. Social activities with your friends, neighbours, or groups?  
   - Not applicable  
   - Not very much  
   - Very much

40. Your religious or spiritual activities?  
   - Not applicable  
   - Not very much  
   - Very much

41. Your involvement in community or civic activities?  
   - Not applicable  
   - Not very much  
   - Very much

42. Your self-improvement or self-expression activities?  
   - Not applicable  
   - Not very much  
   - Very much
You may feel that some of the questions below are not relevant to you. If this is the case, just ask yourself how confident you would feel in dealing with it if it 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?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>
The following questions are about your feelings in the past 4 weeks.

*Please tick one box for each question.*

<table>
<thead>
<tr>
<th>Question</th>
<th>All of the time (1)</th>
<th>Most of the time (2)</th>
<th>Some of the time (3)</th>
<th>A little of the time (4)</th>
<th>None of the time (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>49. <em>In the past 4 weeks,</em> about how often did you feel tired out for no good reason?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>50. <em>In the past 4 weeks,</em> about how often did you feel nervous?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>51. <em>In the past 4 weeks,</em> about how often did you feel so nervous that nothing could calm you down?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>52. <em>In the past 4 weeks,</em> about how often did you feel hopeless?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>53. <em>In the past 4 weeks,</em> about how often did you feel restless or fidgety?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>54. <em>In the past 4 weeks,</em> about how often did you feel so restless you could not sit still?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>55. <em>In the past 4 weeks,</em> about how often did you feel depressed?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>56. <em>In the past 4 weeks,</em> about how often did you feel that everything was an effort?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>57. <em>In the past 4 weeks,</em> about how often did you feel so sad that nothing could cheer you up?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>58. <em>In the past 4 weeks,</em> about how often did you feel worthless?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
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.*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Slightly disagree</th>
<th>Neither agree or disagree</th>
<th>Slightly agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>59. In most ways my life is close to ideal. ……</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>60. The conditions of my life are excellent.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>61. I am satisfied with my life. ........................................</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>62. So far I have gotten the important things I want in life. ………..</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>63. If I could live my life over, I would change almost nothing. ………...</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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”).

<table>
<thead>
<tr>
<th>Provider</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>64. A General Practitioner? ………………………………………………….</td>
<td>☐</td>
</tr>
<tr>
<td>65. A Specialist? (for example, Cardiologist) ……………………………….</td>
<td>☐</td>
</tr>
<tr>
<td>66. A Practice Nurse or a Community Nurse? ……………………………….</td>
<td>☐</td>
</tr>
<tr>
<td>67. An Aboriginal Health Worker? ………………………………………….</td>
<td>☐</td>
</tr>
<tr>
<td>68. Another type of health professional? (for example, Podiatrist, Occupational Therapist, Physiotherapist). …………………….</td>
<td>☐</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>IF YES, how often?</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than once a week</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Once a week</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2-3 times a week</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Daily</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>More than daily</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>IF YES, please tell us what these are...</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self help / support group 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self help / support group 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self help / support group 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IF YES, how did you find out about these self help / support groups?

Please tick the appropriate boxes.

- Friend/Neighbour/Relative ☐
- Health Service Provider ☐
- Television/Radio/Newspaper ☐
- The Sharing Health Care Initiative ☐
- Other ☐

Specify: ____________________________

ID: 11
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:  

Date of Birth: 

Date of recruitment: 

Date of questionnaire completion: 

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”.

<table>
<thead>
<tr>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A General Practitioner?</td>
</tr>
<tr>
<td>2. A Specialist? (for example, Cardiologist)</td>
</tr>
<tr>
<td>3. A Practice Nurse or a Community Nurse?</td>
</tr>
<tr>
<td>4. An Aboriginal Health Worker?</td>
</tr>
<tr>
<td>5. Another type of health professional? (for example, Podiatrist, Occupational Therapist, Physiotherapist).</td>
</tr>
</tbody>
</table>

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) ……

**IF YES**, how often?

*Please tick one box.*

<table>
<thead>
<tr>
<th>Less than once a week</th>
<th>Once a week</th>
<th>2–3 times a week</th>
<th>Daily</th>
<th>More than daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

| ![ ] | ![ ] | ![ ] | ![ ] |

Please tell us what these community services are…

- Community service 1
- Community service 2
- Community service 3
9. Are you currently going to any self-help / support groups? (For example, Huff and Puff Respiratory Support Group) ........

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 ....................... ☐
Health Service Provider ....................... ☐
Television/Radio/Newspaper .................... ☐
The Sharing Health Care Initiative ............ ☐
Other ............................................. ☐

Specify: ________________________________
Thank you again for taking the time to complete this questionnaire
Appendix 18

Indigenous Client Information Questionnaire – Pika Wiya (SA)
CLIENT INFORMATION QUESTIONNAIRE

1. Are you male or female?

Please tick one box.

Male ........................................... ☐

Female ....................................... ☐

2. What is your date of birth?

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

*If Yes, specify: _________________________________*

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

<table>
<thead>
<tr>
<th>Yes, Aboriginal</th>
<th>Yes, Torres Strait Islander</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Never married</th>
<th>Widowed</th>
<th>Divorced</th>
<th>Separated but not divorced</th>
<th>Married (including de facto)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### 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’.*

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

---

3

ID: 9
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 ........................................... □
- Did not go to school ................................... □
- Year 8 or below ........................................... □
- Year 9 or equivalent ................................. □
- Year 10 or equivalent ............................... □
- Year 11 or equivalent .............................. □
- Year 12 or equivalent ............................. □

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.


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.


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

Please tick the appropriate boxes.

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

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

- I live alone ...........................................  
- I live with family ....................................  
- I live with others ....................................  

*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.

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

<table>
<thead>
<tr>
<th>Option</th>
<th>Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have a carer</td>
<td>☐</td>
</tr>
<tr>
<td>I do not have a carer</td>
<td>☐</td>
</tr>
</tbody>
</table>

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.*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>1,2</td>
</tr>
<tr>
<td>Arthritis, or other joint/bone condition</td>
<td>1,2</td>
</tr>
<tr>
<td>Specify</td>
<td></td>
</tr>
<tr>
<td>Chronic respiratory/lung condition</td>
<td>1,2</td>
</tr>
<tr>
<td>Specify</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular disease (including stroke, high blood pressure and angina)</td>
<td>1,2</td>
</tr>
<tr>
<td>Specify</td>
<td></td>
</tr>
<tr>
<td>Renal Disease</td>
<td>1,2</td>
</tr>
<tr>
<td>Specify</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>1,2</td>
</tr>
<tr>
<td>Specify</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>1,2</td>
</tr>
<tr>
<td>Specify</td>
<td></td>
</tr>
<tr>
<td>Other chronic condition</td>
<td>1,2</td>
</tr>
<tr>
<td>Specify</td>
<td></td>
</tr>
</tbody>
</table>

15. Which condition gives you most trouble?

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
</tbody>
</table>

6  ID: 9
16. Which of the following best describes your smoking status?  
*Please tick one box.*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I smoke daily</td>
<td>1</td>
</tr>
<tr>
<td>I smoke occasionally</td>
<td>2</td>
</tr>
<tr>
<td>I don’t smoke now, but I used to</td>
<td>3</td>
</tr>
<tr>
<td>I have tried it a few times, but never smoked regularly</td>
<td>4</td>
</tr>
<tr>
<td>I have never smoked</td>
<td>5</td>
</tr>
</tbody>
</table>

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Every day</td>
<td>01</td>
</tr>
<tr>
<td>6 days a week</td>
<td>02</td>
</tr>
<tr>
<td>5 days a week</td>
<td>03</td>
</tr>
<tr>
<td>4 days a week</td>
<td>04</td>
</tr>
<tr>
<td>3 days a week</td>
<td>05</td>
</tr>
<tr>
<td>2 days a week</td>
<td>06</td>
</tr>
<tr>
<td>1 day a week</td>
<td>07</td>
</tr>
<tr>
<td>Fortnightly or less</td>
<td>08</td>
</tr>
<tr>
<td>Monthly or less</td>
<td>09</td>
</tr>
<tr>
<td>I don’t drink alcohol</td>
<td>10</td>
</tr>
</tbody>
</table>
**Alcoholic drinks are measured in terms of a ‘standard drink’.

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

**A standard drink is equal to:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Schooner of regular beer, <strong>OR</strong></td>
</tr>
<tr>
<td>1</td>
<td>Pint of light beer, <strong>OR</strong></td>
</tr>
<tr>
<td>1</td>
<td>Glass of wine, <strong>OR</strong></td>
</tr>
<tr>
<td>1</td>
<td>Nip of spirits</td>
</tr>
</tbody>
</table>

*Please tick one box.*

| 1 drink ........................................ | ☐ |
| 2 drinks ....................................... | ☐ |
| 3 to 4 drinks. ................................ | ☐ |
| 5 drinks ....................................... | ☐ |
| 6 drinks ....................................... | ☐ |
| 7 to 8 drinks .................................. | ☐ |
| 9 to 12 drinks ............................... | ☐ |
| 13 drinks or more ............................ | ☐ |
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……………….  
Community:  2……
Six months…………….       3……
End of project………..

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:  

Other:  

ID:  

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: ☐ ☐ ☐ ☐ ☐ ☐
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............................
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….. [ ]
CLIENT INFORMATION QUESTIONNAIRE

Office use only:

Identification number: 

Date of recruitment: 

Date of questionnaire completion: 

Administration point: 
(tick appropriate box) 
Baseline……………………
Community: 
Six months………………
End of project…………

ID: 

8
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:  

ID:  

Lajamanu
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

11  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

12 ID: [boxes]
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.....
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:
1. **In general**, do you think your health is:  
*Please tick one box.*

- Excellent
- Very Good
- Good
- Fair
- Poor

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

<table>
<thead>
<tr>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A good bit of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

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:*

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not weary</td>
<td>Severe weariness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:*

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No shortness</td>
<td>Severe shortness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specify Cause(s): ____________________________________________

---

ID: [ ] [ ] [ ] [ ]
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:

0 1 2 3 4 5 6 7 8 9 10

No pain Severe pain

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

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.

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
   1 2 3 4 5 6 7
   Not very much Very much

21. The things you eat and drink? □ Not applicable
   1 2 3 4 5 6 7
   Not very much Very much

22. Your work, including job, house work, chores, or errands? □ Not applicable
   1 2 3 4 5 6 7
   Not very much Very much

23. Playing sports, gardening, or other physical recreation or hobbies? □ Not applicable
   1 2 3 4 5 6 7
   Not very much Very much

24. Quiet recreation or hobbies, such as reading, TV, music, knitting etc.? □ Not applicable
   1 2 3 4 5 6 7
   Not very much Very much
How much does your condition and/or its treatment affect:

25. Your financial situation? □ Not applicable

1 2 3 4 5 6 7
Not very much Very much

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

1 2 3 4 5 6 7
Not very much Very much

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

1 2 3 4 5 6 7
Not very much Very much

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

1 2 3 4 5 6 7
Not very much Very much

29. Your religious or spiritual activities? □ Not applicable

1 2 3 4 5 6 7
Not very much Very much
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)?
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.**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>More than 5 days a week</th>
<th>4-5 days a week</th>
<th>2-3 days a week</th>
<th>About 1 day a week</th>
<th>2-3 days a month</th>
<th>About 1 day a month</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>36. A General Practitioner?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>37. A Specialist? (for example, Cardiologist)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>38. A Practice Nurse or a Community Nurse?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>39. An Aboriginal Health Worker?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>40. Another type of health professional? (for example, Podiatrist, Occupational Therapist, Physiotherapist)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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 2

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

<table>
<thead>
<tr>
<th>Frequency</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than once a week</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Once a week</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>2–3 times a week</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>More than daily</td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>

Please tell us what these community services are…

Community service 1

Community service 2

Community service 3
44. Are you currently going to any self-help / support groups? (For example, Huff and Puff Respiratory Support Group)……..

   □ 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: ________________________________
Thank you again for taking the time to complete this questionnaire