ACT Annual Questionnaire

18 Years of Age or Older Self Report

The questions in this booklet relate to:

Person completing this questionnaire is:

Your relationship:

☐ Self

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
m m d d y y y y

MRN: ☐☐☐☐☐

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Please! Do not mark below this line

Survey #235

4182244375

03/13/2018 10:07:58 AM

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

Please follow these rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call 1-800-775-2167.

1. Use a black ballpoint pen or a number 2 black pencil. Do not use a felt-tip or roller-ball pen. These may cause smudging. If you must erase answers, erase them completely.
2. When marking boxes, make an x inside the box (see examples below).
3. Make no stray marks of any kind. Please keep the form as clean as possible.
4. Written responses must stay within the boxes provided:

CORRECT

Grape

INCORRECT

MARKING EXAMPLES

Below are some examples of how to fill out this questionnaire. Please look these over before you begin.

Example 1

1. During the past month, did your child participate in any physical activities or exercises such as running, aerobics, golf, gardening, bicycling, swimming, wheelchair basketball, or walking for exercise?

☐ No ☒ Yes

Example 2

2. Has your child ever taken. . .

	No	Yes	Not sure	If yes, age at first use
a. PILLS OR INSULIN FOR DIABETES such as Glucophage (metformin), Glucotrol (glipizide), Glynase (glyburide), Prandin, Amaryl, Avandia, Actos, or insulin injections (such as Humulin, Novolin, Lantus)----------	X	☐	☐	
If yes, specify the name of the drug(s) or indicate you do not know the specific name				
b. MEDICATIONS FOR ATTENTION OR MEMORY PROBLEMS such as Ritalin, Adderall, Concerta, Strattera, Aricept (donepezil), or Provigil (modafinil)----------		☒	☐	10
If yes, specify the name of the drug(s) or indicate you do not know the specific name		ritalin		

Example 3

3. When was this condition diagnosed?

0 4	2 0 0 0
Month (mm)	Year (yyyy)

Please! Do not mark below this line

Current Health Problems (Review of Systems)

Are you **currently having problems** with any of the conditions below:

	No	Yes
Frequent headaches	☐	☐
Problems seeing	☐	☐
Problems hearing	☐	☐
Dizziness or unsteadiness	☐	☐
Problems walking	☐	☐
Frequently tired	☐	☐
Changes in appetite or eating habits	☐	☐
Sensitivity to heat or cold	☐	☐
Chest pain	☐	☐
Rapid or irregular heartbeat	☐	☐
Frequent or severe belly pain	☐	☐
Frequent constipation	☐	☐
Frequent diarrhea	☐	☐
Frequent need to urinate	☐	☐
Burning or pain with urination	☐	☐
Back pain	☐	☐
Any other chronic pain	☐	☐
Problems with menstrual periods	☐	☐
Heavy periods with excessive bleeding	☐	☐
Irregular or frequently missed periods	☐	☐
Severe cramping	☐	☐
Problems with sexual functioning	☐	☐
Problems with memory, thinking, forgetting which affect school or work performance	☐	☐
Problems controlling temper or anger	☐	☐
Difficulty getting along with others	☐	☐
Increased worries or upsetting thoughts	☐	☐
Problems with anxiety/panic attacks	☐	☐
Frequently feeling sad, blue or depressed	☐	☐
Problems sleeping or frequent use of sleep medicines	☐	☐
Increased use of tobacco, alcohol or other drugs	☐	☐
Use of over the counter weight loss medicine	☐	☐

→ *Please continue on next page.*

Please! Do not mark below this line

Medical Information

Please provide the name, address, and telephone number of the patient's physician and specialty physician.

Primary Care Physician:

Doctor's name
Street
City, State, Zip
Phone

Specialty Physician (Example: Endocrinologist):

Doctor's name
Street
City, State, Zip
Phone
Specialty

Specialty Physician (Example: Endocrinologist):

Doctor's name
Street
City, State, Zip
Phone
Specialty

Specialty Physician (Example: Endocrinologist):

Doctor's name
Street
City, State, Zip
Phone
Specialty

Interval History

Medical Check-Ups:

A1. Have you seen a doctor since your last St. Jude visit?

☐ No → *Go to Question A3.*

☐ Yes

A2. Reason for doctor visit:

☐ Routine check-up; sports or school physical

☐ Illness; indicate approximate date and condition treated

Date
Doctor's name
Medical problem

Date
Doctor's name
Medical problem

A3. Have you seen a dentist since your last St. Jude visit?

☐ No → *Go to Question A5, next page.*

☐ Yes

A4. Reason for dental visit:

☐ Routine check-up

☐ Dental Problem

If dental problem, please specify:

Please! Do not mark below this line

Hospitalizations

A5. Have you been hospitalized since your last St. Jude visit?

☐ No

☐ Yes

Date	Hospital
Medical problem	

Date	Hospital
Medical problem	

Medications and Health Supplements

Medications: List the medicines you take regularly. Remember to include hormones, birth control pills and over the counter medicines.

Name of medicine	Dose of medicine	Reason taken	Prescribing MD

Health Supplements: List herbs, supplements and other natural products you take regularly.

Name of product	Reason taken

Please! Do not mark below this line

Living/Marital Status

B1. What is your current living arrangement? *(Mark all that apply)*

- ☐ Live with spouse/partner
- ☐ Live with parent(s)
- ☐ Live with roommate(s)
- ☐ Live with brother(s) and/or sister(s)
- ☐ Live with other relative(s) (not including minor children)
- ☐ Live alone
- ☐ Other *Specify.*

B2. Have you ever been married or had a live-in relationship (lived as married)?

- ☐ No → *Go to Question B4.*
- ☐ Yes

B3. Which of the following best describes your current marital status?

- ☐ Single, never married or never lived with partner as married
- ☐ Married
- ☐ Living with a partner as married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated or no longer living as married

Driver's License

B4. Do you currently have a driver's license?

- ☐ No
- ☐ Yes

School History

B5. What is the highest grade or level of schooling that you have completed?

- ☐ 1 - 8 years (grade school)
- ☐ 9 - 12 years (high school), but did not graduate
- ☐ Completed high school/GED
- ☐ Training after high school, other than college
- ☐ Some college
- ☐ College graduate
- ☐ Post-graduate level
- ☐ Other *Specify.*

B6. If still in high school or college, what is your grade point average (GPA)?

☐ . ☐

Insurance

B7. Do you currently have health insurance coverage?

- ☐ Non - U.S. resident/citizen → *Go to Question C1.*
- ☐ No → *Go to Question C1.*
- ☐ Yes

B8. How is this insurance provided? *(Mark all that apply)*

- ☐ Through your place of employment/education
- ☐ Through your spouse's or parent's policy
- ☐ Through a policy you have purchased yourself
- ☐ Affordable Care Act (Obama Care)
- ☐ Medicaid or other public assistance program
- ☐ Medicare
- ☐ Military dependent/Veteran's benefits (CHAMPUS)
- ☐ Other *Specify.*

Please! Do not mark below this line

Sun Sensitivity

C1. Have you ever used artificial tanning devices such as a sunlamp, or gone to a tanning booth?

- ☐ No
- ☐ Yes

C2. When you were outside last summer for more than 15 minutes, how often did you protect yourself from the sun by . . .

	Never	Rarely	Sometimes	Often	Always
Applying a sunscreen with a sun protection factor (SPF) of 15 or more on all sun exposed skin areas.	☐	☐	☐	☐	☐
Wearing protective clothing such as long-sleeved shirts and long pants.	☐	☐	☐	☐	☐
Wearing a hat.	☐	☐	☐	☐	☐
Limiting exposure to the sun during the mid-day hours.	☐	☐	☐	☐	☐
Staying in the shade.	☐	☐	☐	☐	☐

Daily Activity

C3. Which statement best describes your usual daily activities?

- ☐ I mostly sit during the day and do not walk about very much
- ☐ I stand or walk about quite a lot during the day, but do not have to carry or lift things very often
- ☐ I carry light loads, or have to climb stairs or hills often
- ☐ I do heavy work or carry heavy loads

C4. Over the <u>past 30 days</u>, on a typical day how much time altogether did you spend sitting and watching TV or videos or using a computer outside of work? Would you say ...

- ☐ Don't watch TV or videos or use a computer
- ☐ <1 hour
- ☐ 1 hour
- ☐ 2 hours
- ☐ 3 hours
- ☐ 4 hours
- ☐ 5 hours or more

→ *Please continue on next page.*

HEALTH HABITS

Smoking

D1. In the past year, have you ever used any of these tobacco products? ***(Mark all that apply)***

	Never used	No longer use	Occasionally use	Regularly use
Chewing tobacco	☐	☐	☐	☐
Snuff tobacco	☐	☐	☐	☐
Pipes	☐	☐	☐	☐
Cigars	☐	☐	☐	☐
Cigarettes	☐	☐	☐	☐
E-Cigarettes	☐	☐	☐	☐

Alcohol

D2. During the last 12 months, how often did you usually have any kind of drink containing alcohol?

- ☐ Every day
- ☐ 5 to 6 times a week
- ☐ 3 to 4 times a week
- ☐ twice a week
- ☐ once a week
- ☐ 2 to 3 times a month
- ☐ once a month
- ☐ 3 to 11 times in the past year
- ☐ 1 or 2 times in the past year
- ☐ Never in the past year

Sexual behavior

D3. Are you sexually active?

☐ No → *Go to D6.*

☐ Yes

D4. Number of sexual partners in . . .

last 3 months ☐☐

last 12 months ☐☐

lifetime ☐☐

D5. How often did you use condoms with a partner in the last 3 months?

- ☐ Always
- ☐ More than half the time
- ☐ Half the time
- ☐ Less than half the time
- ☐ Never

Drug Use

D6. During the past 30 days, how many times did you use…

	Never	1 - 2 times	3 - 9 times	10 - 19 times	20 - 39 times	40 or more
Marijuana/Hashish/Cannabis	☐	☐	☐	☐	☐	☐
Cocaine/Crack/Freebase	☐	☐	☐	☐	☐	☐
Methamphetamine/Speed/ Ice/Crystal Meth/Ecstasy	☐	☐	☐	☐	☐	☐
Sniffing glue/breathing aerosol spray cans/inhaling paints	☐	☐	☐	☐	☐	☐
Heroin/Smack/Junk/White China	☐	☐	☐	☐	☐	☐
Hallucinogenic Drugs/ LSD/acid/PCP/angel dust/mescaline/mushrooms	☐	☐	☐	☐	☐	☐

D7. During the past 30 days, how many times did you use without a doctor's prescription...

	Never	1 - 2 times	3 - 9 times	10 - 19 times	20 - 39 times	40 or more
Steroid Pills or Shots	☐	☐	☐	☐	☐	☐
Prescription Drugs (OxyContin/Percocet/Vicodin/ Codeine/Adderall/Ritalin/ Xanax)	☐	☐	☐	☐	☐	☐

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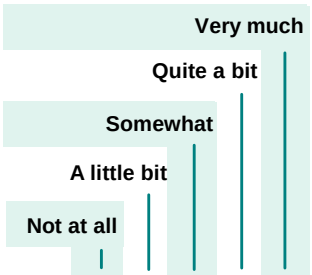
Pain Interference

Questions E1 to E6 relate to the past 7 days.



E1. How much did pain interfere with your day to day activities? . . . . . ☐ ☐ ☐ ☐ ☐

E2. How much did pain interfere with work around the home? . . . . . ☐ ☐ ☐ ☐ ☐

E3. How much did pain interfere with your ability to participate in social activities? . . . . . ☐ ☐ ☐ ☐ ☐

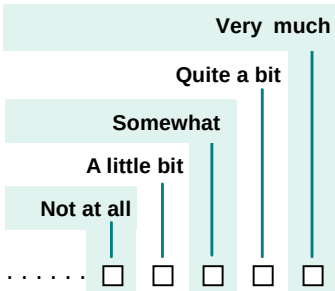
E4. How much did pain interfere with your household chores? . . . . . ☐ ☐ ☐ ☐ ☐

E5. How much did pain interfere with the things you usually do for fun?. . . . . ☐ ☐ ☐ ☐ ☐

E6. How much did pain interfere with your enjoyment of social activities? . . . . . ☐ ☐ ☐ ☐ ☐

Sleep

Questions F1 to F8 relate to the past 7 days.

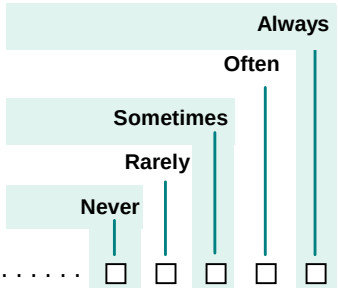


F1. My sleep was restless . . . . . ☐ ☐ ☐ ☐ ☐

F2. I was satisfied with my sleep . . . . . ☐ ☐ ☐ ☐ ☐

F3. My sleep was refreshing. . . . . ☐ ☐ ☐ ☐ ☐

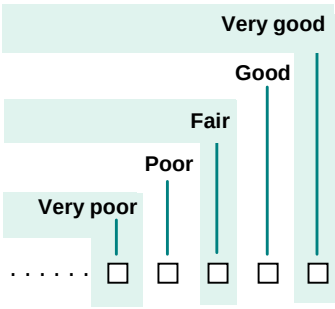
F4. I had difficulty falling asleep. . . . . ☐ ☐ ☐ ☐ ☐



F5. I had trouble staying asleep . . . . . ☐ ☐ ☐ ☐ ☐

F6. I had trouble sleeping . . . . . ☐ ☐ ☐ ☐ ☐

F7. I got enough sleep. . . . . ☐ ☐ ☐ ☐ ☐



F8. My sleep quality was . . . . . ☐ ☐ ☐ ☐ ☐

Please continue on next page.

Please! Do not mark below this line

G. Below is a list of statements that describe problems people can have. We would like to know if you have had any of these problems over the <u>past 6 months</u>. Please complete all items. Please think about yourself as you read these statements and mark one response on each line.

	Never a problem	Sometimes a problem	Often a problem
1. I get upset easily.	☐	☐	☐
2. It takes me longer to complete my work.	☐	☐	☐
3. I am disorganized.	☐	☐	☐
4. I forget instructions easily.	☐	☐	☐
5. I have problems completing my work.	☐	☐	☐
6. I have difficulty recalling things I had previously learned (e.g., names, places, events, activities).	☐	☐	☐
7. I get frustrated easily.	☐	☐	☐
8. My mood changes frequently.	☐	☐	☐
9. I have trouble finding things in my bedroom, closet or desk.	☐	☐	☐
10. I forget what I am doing in the middle of things.	☐	☐	☐
11. I have problems getting started on my own.	☐	☐	☐
12. I am easily overwhelmed.	☐	☐	☐
13. I have trouble doing more than one thing at a time.	☐	☐	☐
14. My desk/workspace is a mess.	☐	☐	☐
15. I have trouble remembering things, even for a few minutes (such as directions, phone numbers, etc.).	☐	☐	☐
16. I have trouble prioritizing my activities.	☐	☐	☐
17. I read slowly.	☐	☐	☐
18. I am slower than others when completing my work.	☐	☐	☐
19. I have trouble solving math problems in my head.	☐	☐	☐
20. I don't work well under pressure.	☐	☐	☐
21. I have trouble staying on the same topic when talking.	☐	☐	☐
22. I have a messy closet.	☐	☐	☐
23. People say I am easily distracted.	☐	☐	☐
24. I have angry outbursts.	☐	☐	☐
25. I have a short attention span.	☐	☐	☐
26. I overreact emotionally.	☐	☐	☐
27. I have trouble organizing work.	☐	☐	☐
28. I overreact to small problems.	☐	☐	☐
29. I have problems organizing activities.	☐	☐	☐
30. I have emotional outbursts for little reason.	☐	☐	☐
31. I leave the bathroom a mess.	☐	☐	☐
32. I react more emotionally to situations than my friends.	☐	☐	☐
33. I leave my room or home a mess.	☐	☐	☐

→ *Please continue on next page.*

Please! Do not mark below this line

Below is a list of problems people sometimes have. Please read each one carefully and mark the box that best describes how much that problem has <u>distressed or bothered you during the past 7 days</u> including today. *Mark only one answer for each problem and try not to skip any items.*

	Not at all	A little bit	Moderately	Quite a bit	Extremely
H1. Nervousness or shaking inside.	☐	☐	☐	☐	☐
H2. Faintness or dizziness.	☐	☐	☐	☐	☐
H3. Pains in heart or chest.	☐	☐	☐	☐	☐
H4. Thoughts of ending your life	☐	☐	☐	☐	☐
H5. Suddenly scared for no reason.	☐	☐	☐	☐	☐
H6. Feeling lonely.	☐	☐	☐	☐	☐
H7. Feeling blue.	☐	☐	☐	☐	☐
H8. Feeling no interest in things	☐	☐	☐	☐	☐
H9. Feeling fearful	☐	☐	☐	☐	☐
H10. Nausea or upset stomach.	☐	☐	☐	☐	☐
H11. Trouble getting your breath.	☐	☐	☐	☐	☐
H12. Numbness or tingling in parts of your body.	☐	☐	☐	☐	☐
H13. Feeling hopeless about the future.	☐	☐	☐	☐	☐
H14. Feeling weak in parts of your body	☐	☐	☐	☐	☐
H15. Feeling tense or keyed up.	☐	☐	☐	☐	☐
H16. Spells of terror or panic.	☐	☐	☐	☐	☐
H17. Feeling so restless you couldn't sit still.	☐	☐	☐	☐	☐
H18. Feelings of worthlessness.	☐	☐	☐	☐	☐

I1. At any time in the <u>past 12 months</u>, that is up to and including today, did you seriously think about trying to kill yourself?

☐ No

☐ Yes

I2. During the <u>past 12 months</u>, did you make any plans to kill yourself?

☐ No

☐ Yes

I3. During the <u>past 12 months</u>, did you try to kill yourself?

☐ No

☐ Yes

I4. During the <u>past 12 months</u>, did you get medical attention from a doctor or health professional as a result of an attempt to kill yourself?

☐ No

☐ Yes

I5. During the <u>past 12 months</u>, did you stay in a hospital overnight or longer because you tried to kill yourself?

☐ No

☐ Yes

Please! Do not mark below this line

We are always interested in your input.
Use this space for any additional comments you may have:

Do you have an email address we could use to contact you?

☐ No ☐ Yes

Your Email Address

Please give us your correct address or location and also cell phone number:

Address		
City		State
Zip Code	Home Phone Number	Cell Phone Number

Please! Do not mark below this line

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