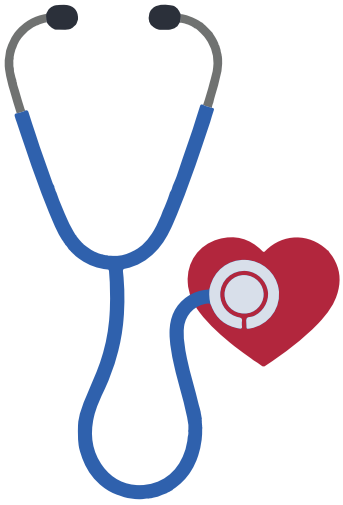

CARE

Cancer & Aging Resilience Evaluation

Full name: _____

Today's Date: | | | / | | | / | | | | |

Instructions: Please answer the questionnaire to the best of your ability. Please mark boxes with an "x" or a check. If you make a mistake, please mark out the incorrect answer and mark an "x" in the correct box and circle it.

Example: ☒ Yes ☐ No ☒ Yes ☒ No

1. How many times have you fallen in the last 6 months? | |

2. Does your health limit you in walking one block? ☐ Not limited at all ☐ Limited a little ☐ Limited a lot

3. Can you get to places out of walking distance...

   ☐ Without help (drive your own car, or travel alone on buses or taxis);
   ☐ With some help (need someone to help you or go with you when traveling); or
   ☐ Are you unable to travel unless emergency arrangements are made for specialized vehicle like an ambulance?

4. Can you go shopping for groceries or clothes (assuming you have transportation)...

   ☐ Without help (taking care of all shopping needs yourself, assuming you had transportation);
   ☐ With some help (need someone to go with you on shopping trips); or
   ☐ Are you completely unable to do any shopping?

5. Can you prepare your own meals...

   ☐ Without help (plan and cook all meals yourself);
   ☐ With some help (can prepare somethings but unable to cook full meals yourself); or
   ☐ Are you completely unable to prepare any meals?

6. Can you do your housework...

   ☐ Without help (can clean floors, etc.);
   ☐ With some help (can do light housework but need help with heavy work); or
   ☐ Are you completely unable to do any housework?

7. Can you take your own medicines...

   ☐ Without help (in the right doses at the right time);
   ☐ With some help (able to take medicine if someone prepares it for you and/or reminds you); or
   ☐ Are you completely unable to take your medicines?

8. Can you handle your own money...

   ☐ Without help (write checks, pay bills, etc.);
   ☐ With some help (manage day-to-day buying but need help with managing your checkbook and paying your bills); or
   ☐ Are you completely unable to handle money?

9. Can you get in and out of bed...

   ☐ Without any help or aids;
   ☐ With some help (either from a person or with the aid of some device); or
   ☐ Are you totally dependent on someone else to lift you?

10. Can you dress and undress yourself...

- ☐ Without help (able to pick out clothes, dress and undress yourself);
- ☐ With some help; or
- ☐ Are you completely unable to dress and undress yourself?

11. Can you take a bath or shower...

- ☐ Without help;
- ☐ With some help (need help getting in and out of the tub or need special attachments); or
- ☐ Are you completely unable to bathe yourself?

	Excellent	Very good	Good	Fair	Poor
In general, would you say your health is:	☐	☐	☐	☐	☐
In general, would you say your quality of life is:	☐	☐	☐	☐	☐
In general, how would you rate your physical health?	☐	☐	☐	☐	☐
In general, how would you rate your mental health, including your mood and your ability to think?	☐	☐	☐	☐	☐
In general, how would you rate your satisfaction with your social activities and relationships?	☐	☐	☐	☐	☐
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	☐	☐	☐	☐	☐

	Completely	Mostly	Moderately	A little	Not at All
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐	☐	☐	☐	☐
	Never	**Rarely**	**Sometimes**	**Often**	**Always**
In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐	☐	☐	☐	☐
	None	**Mild**	**Moderate**	**Severe**	**Very Severe**
In the past 7 days, how would you rate your fatigue on average?	☐	☐	☐	☐	☐

In the past 7 days, how would you rate your pain on average?

No Pain — Worst Pain Imaginable

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Nutrition:

1. Weight

I currently weigh _____ pounds, and I am _____ feet and _____ inches tall

One month ago I weighed about _____ pounds

Six months ago I weighed about _____ pounds

During the past two weeks my weight has:

☐ Decreased ☐ Not changed ☐ Increased

2. Food intake

As compared to my normal intake, I would rate my food intake during the past month as:

☐ Unchanged

☐ More than usual

☐ Less than usual

I am now taking:

☐ *Normal* food but less than normal

☐ Little solid food

☐ Only liquids

☐ Only nutritional supplements

☐ Very little of anything

☐ Only tube feedings or only nutrition by vein

3. Symptoms I have had the following problems that have kept me from eating enough during the past two weeks (Check *ALL* that apply):

☐ No eating problems

☐ No appetite, just did not feel like eating

☐ Nausea

☐ Constipation

☐ Pain; where? _____

☐ Things taste funny or have no taste

☐ Problems swallowing

☐ Vomiting

☐ Diarrhea

☐ Smells bother me

☐ Feel full quickly

☐ Fatigue

☐ Mouth sores

☐ Dry mouth

☐ Other _____ (examples: depression, money, or dental problems)

4. Activities and Function

Over the past month, I would generally rate my activity as:

☐ Normal activity with no limitations

☐ Not your normal self, but able to be up and about with fairly normal activities

☐ Not feeling up to most things, but in bed or chair less than half the day

☐ Able to do little activity and spend most of the day in bed or chair

☐ Pretty much bedridden, rarely out of bed

KINDS OF SUPPORT Do you have...	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
Someone to help if you were confined to bed	☐	☐	☐	☐	☐
Someone to take you to the doctor if needed	☐	☐	☐	☐	☐
Someone to prepare your meals if you are unable to do it yourself	☐	☐	☐	☐	☐
Someone to help with daily chores if you were sick	☐	☐	☐	☐	☐
Someone to have a good time with	☐	☐	☐	☐	☐
Someone to turn to for suggestions about how to deal with a personal problem	☐	☐	☐	☐	☐
Someone who understands your problems	☐	☐	☐	☐	☐
Someone to love and make you feel wanted	☐	☐	☐	☐	☐

In the past 7 days...	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
I felt fearful	☐	☐	☐	☐	☐
I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐
My worries overwhelmed me	☐	☐	☐	☐	☐
I felt uneasy	☐	☐	☐	☐	☐
I felt worthless	☐	☐	☐	☐	☐
I felt helpless	☐	☐	☐	☐	☐
I felt depressed	☐	☐	☐	☐	☐
I felt hopeless	☐	☐	☐	☐	☐
In the past 7 days...	**Never**	**Rarely**	**Sometimes**	**Often**	**Very often**
My thinking has been slow	☐	☐	☐	☐	☐
It has seemed like my brain was not working as usual	☐	☐	☐	☐	☐
I have had to work harder than usual to keep track of what I was doing	☐	☐	☐	☐	☐
I have had trouble shifting back and forth between different activities that require thinking	☐	☐	☐	☐	☐

1. How many medications do you take on a daily basis? ☐☐

2. How many medical problems do you have other than your cancer? ☐☐

3. Have you been seen in the ER (Emergency Room) in the past year?

   ☐ Yes ☐ No ☐ Don't know/ Not sure

4. Have you been hospitalized (spent at least one night in the hospital) in the past year?

   ☐ Yes ☐ No ☐ Don't know/ Not sure

1. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

2. Compared to others your age, are your social activities more or less limited because of your physical or emotional problems?

☐ Much more limited than others ☐ Somewhat more limited than others ☐ About the same as others ☐ Somewhat less limited than others ☐ Much less limited than others

3. How is your eyesight (with glasses or contacts)?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Totally Blind

4. How is your hearing (with a hearing aid, if needed)?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Totally Deaf

5. Do you have to pay for more medical care than you can afford?

☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

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Your Health: Do you have any of the following illnesses **at the present time**? If you fill in "yes," please tell us how much the illness interferes with your activities:

				IF YOU HAVE THE ILLNESS, how much does it interfere with your activities?		
Illness	**No**	**Yes**	***If Yes...***	**Not at all**	**Somewhat**	**A Great Deal**
Other cancers or leukemia	☐	☐	→	☐	☐	☐
Arthritis or rheumatism	☐	☐	→	☐	☐	☐
Glaucoma	☐	☐	→	☐	☐	☐
Emphysema or chronic bronchitis	☐	☐	→	☐	☐	☐
High blood pressure	☐	☐	→	☐	☐	☐
Heart disease	☐	☐	→	☐	☐	☐
Circulation trouble in arms or legs	☐	☐	→	☐	☐	☐
Diabetes	☐	☐	→	☐	☐	☐
Stomach or intestinal disorders	☐	☐	→	☐	☐	☐
Osteoporosis	☐	☐	→	☐	☐	☐
Chronic liver or kidney disease	☐	☐	→	☐	☐	☐
Stroke	☐	☐	→	☐	☐	☐
Depression	☐	☐	→	☐	☐	☐

Demographics

1. What is the highest grade you finished in school?
   - ☐ 1-8 grades
   - ☐ 9-11 grades
   - ☐ High school graduate
   - ☐ Some college
   - ☐ Junior college degree
   - ☐ College degree (B.A./B.S.)
   - ☐ Some post-college work
   - ☐ Advanced degree

2. What is your current marital status?
   - ☐ Single, never married
   - ☐ Married
   - ☐ Separated
   - ☐ Divorced
   - ☐ Widowed

3. What is your race? (Check *ALL* that apply)
   - ☐ White
   - ☐ Black or African American
   - ☐ Native American or Alaskan Native
   - ☐ Asian
   - ☐ Native Hawaiian
   - ☐ Other, specify: _____

4. What is your ethnicity?
   - ☐ Hispanic or Latino
   - ☐ Non-Hispanic

5. What is your current employment status? (Check *ALL* that apply)
   - ☐ Employed more than 32 hours per week
   - ☐ Employed less than 32 hours per week
   - ☐ Full-time or Part-time student
   - ☐ On medical leave
   - ☐ Other, specify: _____
   - ☐ Disabled
   - ☐ Unemployed
   - ☐ Retired
   - ☐ Homemaker

6. With whom do you live? (Check *ALL* that apply)
   - ☐ Spouse/Partner
   - ☐ Parent(s)/Parent(s)-In-Law
   - ☐ Live alone
   - ☐ Children aged 18 years or younger
   - ☐ Children aged 19 years or older
   - ☐ Other, specify: _____

Your Feedback:

1. About how long did it take you to complete the questionnaire?

   | | | | minutes

2. Were any of these questions difficult to understand?
   - ☐ No
   - ☐ Yes, which questions were they?

3. Was the time it took to answer all the questions too long, just right, or too short?
   - ☐ Too short
   - ☐ Just right
   - ☐ Too long

4. Did you require assistance with the questionnaire?
   - ☐ No
   - ☐ Yes → If yes, who helped you complete this questionnaire? _____

THANK YOU for taking the time to complete the questionnaire!