

1. Age: _____

2. Are you:

- | | |
|--------------------------|-------|
| <input type="checkbox"/> | Man |
| <input type="checkbox"/> | Woman |

3. What is the highest educational level you have completed?

- | | |
|--------------------------|-------------------------|
| <input type="checkbox"/> | Elementary school |
| <input type="checkbox"/> | High school |
| <input type="checkbox"/> | College/university |
| <input type="checkbox"/> | Post-graduate education |

4. Have you at any point in life used any form of so called complementary and alternative methods?

- Yes Continue with question 6
- No Continue with question 5

5. Please check the main reason(s) for not using any complementary and alternative methods:

You can check several answer options.

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Never thought about using complementary and alternative methods |
| <input type="checkbox"/> | I do not believe in methods lacking scientific proof |
| <input type="checkbox"/> | I am happy with the care and treatment I receive at the department of oncology |
| <input type="checkbox"/> | I cannot afford complementary and/or alternative methods |
| <input type="checkbox"/> | I've thought about using complementary and alternative methods but was discouraged by family/friends/health professionals and decided therefore not to do so |
| <input type="checkbox"/> | Other reason: _____

_____ |

6. Have you used any of the following complementary and alternative methods before or after your cancer diagnosis? What of these methods are you currently using?

You can check several answer options

	Used before cancer diagnosis	Used after cancer diagnosis
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>
Spiritual guidance, healing	<input type="checkbox"/>	<input type="checkbox"/>
Anthroposofic medicine	<input type="checkbox"/>	<input type="checkbox"/>
Aroma therapy	<input type="checkbox"/>	<input type="checkbox"/>
Relaxation	<input type="checkbox"/>	<input type="checkbox"/>
Ayurveda	<input type="checkbox"/>	<input type="checkbox"/>
Birch ash	<input type="checkbox"/>	<input type="checkbox"/>
Prayer	<input type="checkbox"/>	<input type="checkbox"/>
Energy medicine	<input type="checkbox"/>	<input type="checkbox"/>
Homeopathy	<input type="checkbox"/>	<input type="checkbox"/>
Hypnosis	<input type="checkbox"/>	<input type="checkbox"/>
Colloidal silver	<input type="checkbox"/>	<input type="checkbox"/>
Art therapy	<input type="checkbox"/>	<input type="checkbox"/>
Changes in diet beyond those recommended at the department of oncology	<input type="checkbox"/>	<input type="checkbox"/>
Laser therapy	<input type="checkbox"/>	<input type="checkbox"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>
Mindfulness	<input type="checkbox"/>	<input type="checkbox"/>
Meditation	<input type="checkbox"/>	<input type="checkbox"/>
Mistletoe injections	<input type="checkbox"/>	<input type="checkbox"/>
Naprapathy, Chiropractic treatment	<input type="checkbox"/>	<input type="checkbox"/>
Natural preparations / health food preparations, Ex. omega-3, turmeric, apricot kernels, aloe vera, russian root, dandelion root	<input type="checkbox"/>	<input type="checkbox"/>
<i>Please specify:</i>		
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

_____	<input type="checkbox"/>	<input type="checkbox"/>
Herbal Remedies / Herbal medicines from pharmacies, ex. echinacea, garlic Please specify:	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
Rosen therapy	<input type="checkbox"/>	<input type="checkbox"/>
Shiatsu	<input type="checkbox"/>	<input type="checkbox"/>
Support groups	<input type="checkbox"/>	<input type="checkbox"/>
Tai Qi/Qi gong	<input type="checkbox"/>	<input type="checkbox"/>
Herbal tea (e.g. Green tea, Pau D'arco) Please specify:	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
Tea from ticks (e.g. Chaga) Please specify:	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
Traditional Chinese Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins and minerals, e.g. C-vitamin, D- vitamin, multivitamins, selen :	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
Yoga	<input type="checkbox"/>	<input type="checkbox"/>
Reflexology	<input type="checkbox"/>	<input type="checkbox"/>
Others, please specify:	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

If you have not used any of the methods above after your cancer diagnosis→Continue with question 15.

7. If you began using complementary and/or alternative therapies after you knew you had cancer, when did you begin using these therapies?

8. Please give the reason why you are using or have used complementary and alternative methods.

You can check several answer options. Specify the method in the right column.

		Method
<input type="checkbox"/>	To fight cancer	
<input type="checkbox"/>	To improve the body's ability to fight cancer	
<input type="checkbox"/>	To improve physical well-being	
<input type="checkbox"/>	To improve emotional well-being	
<input type="checkbox"/>	To improve general well-being	
<input type="checkbox"/>	To relieve symptoms from cancer disease	
<input type="checkbox"/>	To relieve side-effects from oncological treatment	
<input type="checkbox"/>	Other: _____	

9. What benefit have you experienced from the used complementary and alternative methods?

You can check several answer options. Specify the method in the right column.

		Method
<input type="checkbox"/>	Direct decrease of tumor as a result from using complementary and alternative methods	
<input type="checkbox"/>	Increase in my body's ability to fight cancer	
<input type="checkbox"/>	Improvement of physical well-being	
<input type="checkbox"/>	Improvement of emotional well-being	
<input type="checkbox"/>	To improve general well-being	
<input type="checkbox"/>	Reduction of symptoms from cancer disease	
<input type="checkbox"/>	Reduction of side-effects from oncological treatment	
<input type="checkbox"/>	Other: _____	
<input type="checkbox"/>	No benefit at all	

10. Have you experienced any ill effects or side-effects, which you attribute to the complementary and alternative therapy?

Yes → Specify *what* and *I* relation to what *method* below

No

<u>Method</u>	<u>Ill effect or side-effect</u>

11. How much do you currently spend on complementary and alternative methods (incl. products and treatments) in one month? (Please check)

0 SEK

500 SEK or less

501-1000 SEK

1001-5000 SEK

5001-10 000 SEK

10 000 SEK or more

12. Do you think the complementary and alternative methods you have used were worth the money?

Yes

No

Please comment:

13. How satisfied are you with the complementary and alternative method(s) you have used since your cancer diagnosis?

Mark a number 1-4.

1

Not satisfied at all

2

A bit satisfied

3

Quite satisfied

4

Very satisfied

Please comment:

14. Have you discussed use of complementary and alternative methods with your doctor or nurse at the department of oncology/palliative team?

Yes → *Continue with question 14a -14c.*

No → *Continue with question 14d.*

14a. Did you talk to a doctor, nurse or other professional?

Nurse

Doctor

Other professional _____

14b. If so, how was the conversation?

14c. If yes, were you satisfied with the conversation?

Yes

No

Please comment:

14d. If no, please state the reason

15. What was your source of information about complementary and alternative methods?

You can check several answer options.

No one, never heard of it until today

The media (TV, magazines, newspapers)

Internet

Family and friends

Practitioners of complementary and alternative therapies

From primary care/department of oncology/home care

Other: _____

16. In your opinion, should health care providers at the oncology department/palliative team be able to answer questions related to complementary and alternative methods??

Yes

No

No opinion

17. How would you prefer to receive information about complementary and alternative methods from the oncology department/palliative team?

- | | |
|--------------------------|---|
| <input type="checkbox"/> | Written information (webpage or brochure) |
| <input type="checkbox"/> | E-mail/chat forum with possibility to ask questions |
| <input type="checkbox"/> | Personal meeting with a competent person |
| <input type="checkbox"/> | Lecture |
| <input type="checkbox"/> | Other: _____ |

18. In your opinion should certain complementary and alternative methods be offered within oncological care/palliative team?

Yes

No

Please comment:

Thank you for your participation!