Attachment J: BASELINE MEASURES FOR MAIN STUDY (A-CASI)

Form Approved
OMB No. __0920-XXX__
Exp. Date _xx/xx/20xx_

Respondent No. _____

A. Quality of Life: SF-12 Health Survey (Ware, Kisinski, & Keller, 1996)

Please see SF-12® in Attachment L.

B. Disability

1. During the 30 days from { date from 30 days before baseline interview to baseline interview }, about how many days did you miss work because of an illness or injury (do not include maternity leave)? If patient delays answer, audio cues for patient to give best guess.

____ days
____ Don't remember
____ Don't work outside the house

2. During the 30 days from { date from 30 days before baseline interview to baseline interview }, about how many days were you unable to do your housework tasks because of an illness or injury (do not include maternity leave)?
____ days
____ Don't remember

C. Current signs or symptoms

Are you frequently bothered by any of the following problems?		
1. Arthritis or pain, aching, stiffness, or swelling in or around a joint (knee, elbow, hip, fingers, etc.)	YES	NO

2. Neck pain or low back pain	YES	NO
3. Stomach or abdominal pain	YES	NO
4. Pelvic pain	YES	NO
5. Menstrual cramps or other problems with your periods	YES	NO
6. Pain or problems during sexual intercourse	YES	NO
7. Vaginal bleeding or any kind of discharge	YES	NO
8. Vaginal or genital infection	YES	NO
9. Headaches or migraines	YES	NO
10. Nausea, gas, or indigestion	YES	NO
11. Constipation	YES	NO
12. Vomiting or diarrhea	YES	NO
13. Trouble falling asleep or staying asleep on 3 or more nights a week.	YES	NO

D. Health Care Utilization outside Bureau

1. In the past year, have you been admitted to the hospital, stayed at least one night – not just in an emergency room hospitalized in a hospital or clinic other than here at Stroger?
___ Yes → How many times? ____
___ No

2. In the past year, have you gone to an Emergency Department Room other than here at our ER room at County (Stroger)?
___ Yes → How many times? ____
→ Were any of these times because of an injury (like a cut, burn, fracture, bloody nose or mouth)? ___ Yes __ NO
___ No

E. Mental Health (SRQ-20; WHO, 1994)

1. Do you often have headaches?	YES	NO
2. Is your appetite poor?	YES	NO
3. Do you sleep badly?	YES	NO
4. Are you easily frightened?	YES	NO
5. Do your hands shake?	YES	NO
6. Do you feel nervous, tense or worried?	YES	NO
7. Is your digestion poor?	YES	NO
8. Do you have trouble thinking clearly?	YES	NO
9. Do you feel unhappy?	YES	NO

10. Do you cry more than usual?	YES	NO
11. Do you find it difficult to enjoy your daily activities?	YES	NO
12. Do you find it difficult to make decisions?	YES	NO
13. Is your daily work suffering?	YES	NO
14. Are you unable to play a useful part in life?	YES	NO
15. Have you lost interest in things?	YES	NO
16. Do you feel you are a worthless person?	YES	NO
17. Has the thought of ending your life been on your mind?	YES	NO
18. Do you feel tired all the time?	YES	NO
19. Do you have uncomfortable feelings in your stomach?	YES	NO
20. Are you easily tired?	YES	NO

F. Partner Violence Screen (Feldhaus, et al., 1997) **ONLY IN ARM 1**

These next questions refer to violence by intimate partners. Violence is a problem for many women. Because it affects their health, we are asking our patients about it. Just so you know, your answers will not be shared with anyone unless you choose to share them.

1. Have you been hit, kicked, punched, or otherwise hurt by an intimate partner within the past year?
__ YES
__ NO
2. Do you feel safe in your current relationship?
__ YES
__ NO
3. Is there a partner from a previous relationship who is making you feel unsafe now?
__ YES
__ NO