**Form Approved**
OMB No.
Expiration Date:

Attachment 20

Clinic Appointment Packet Materials

<<Health Services Utilization/Sense of Community Questionnaire for Adults>>

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or an other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)

## Utilization of Health Services

**In the next questions, we would like to know about how often you have consulted with a healthcare professional in the past 12 months. By "consulted" we mean that you visited, talked to, or otherwise sought the advice of a healthcare professional. By "healthcare professional," we mean all types of healthcare workers including, but not limited to: medical doctors, nurses, nurse practitioners, physician assistants, dentists, osteopaths, chiropractors, psychologists, healers, etc.**

1. During the **past 12 months**, did you see, talk to, or consult with a healthcare professional about your personal health?

   ❑ 1 Yes

   ❑ 2 No **(SKIP TO 6)**

1A. During the **past 12 months**, how many times did you see, talk to, or consult with a healthcare professional about your personal health?

   _______ Times

2. Have you been fatigued during the **past 12 months**?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 3)**

2A. During the **past 12 months**, did you consult with a healthcare professional because you had problems with fatigue?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 3)**

2B. During the **past 12 months**, how many times did you consult with a healthcare professional because you had problems with fatigue?

_______ Times

2C. What type of healthcare professional did you consult with about your fatigue?

| **Yes** | **No** | |
|---|---|---|
| ❑ 1 | ❑ 2 | Medical doctor |
| ❑ 1 | ❑ 2 | Nurse |
| ❑ 1 | ❑ 2 | Nurse practitioner |
| ❑ 1 | ❑ 2 | Physician assistant |
| ❑ 1 | ❑ 2 | Osteopath |
| ❑ 1 | ❑ 2 | Chiropractor |
| ❑ 1 | ❑ 2 | Psychologist |
| ❑ 1 | ❑ 2 | Healer |
| ❑ 1 | ❑ 2 | Others, specify: _________________________ |

_______________________________________

_______________________________________

_______________________________________

2D. What did the healthcare professional(s) tell you was the reason for your fatigue? Please list all reasons.

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

3. Have you had problems sleeping during the **past 12 months**?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 4)**

3A. During the **past 12 months**, did you consult with a healthcare professional because you had problems sleeping?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 4)**

3B. During the **past 12 months**, how many times did you consult with a healthcare professional because you had problems sleeping?

_______ Times

3C. What type of healthcare professional did you consult with about your sleep problems?

| Yes | No | |
|---|---|---|
| ❑ 1 | ❑ 2 | Medical doctor |
| ❑ 1 | ❑ 2 | Nurse |
| ❑ 1 | ❑ 2 | Nurse practitioner |
| ❑ 1 | ❑ 2 | Physician assistant |
| ❑ 1 | ❑ 2 | Osteopath |
| ❑ 1 | ❑ 2 | Chiropractor |
| ❑ 1 | ❑ 2 | Psychologist |
| ❑ 1 | ❑ 2 | Healer |
| ❑ 1 | ❑ 2 | Others, specify: ___________________________ |

___________________________________________

___________________________________________

___________________________________________

3D. What did the healthcare professional(s) tell you was the reason for your sleep problems? Please list all reasons.

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

4. Have you had memory or concentration problems during the **past 12 months**?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 5)**

4A. During the **past 12 months**, did you consult with a healthcare professional because you had memory or concentration problems?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 5)**

4B. During the **past 12 months**, how many times did you consult with a healthcare professional because you had memory or concentration problems?

_______ Times

4C. What type of healthcare professional did you consult with about your problems with memory or concentration?

| Yes | No | |
|---|---|---|
| ❑ 1 | ❑ 2 | Medical doctor |
| ❑ 1 | ❑ 2 | Nurse |
| ❑ 1 | ❑ 2 | Nurse practitioner |
| ❑ 1 | ❑ 2 | Physician assistant |
| ❑ 1 | ❑ 2 | Osteopath |
| ❑ 1 | ❑ 2 | Chiropractor |
| ❑ 1 | ❑ 2 | Psychologist |
| ❑ 1 | ❑ 2 | Healer |
| ❑ 1 | ❑ 2 | Others, specify: ________________________ |

________________________________________

________________________________________

________________________________________

4D. What did the healthcare professional(s) tell you was the reason for your problems with memory or concentration? Please list all reasons.

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

5. Have you had problems with pain during the **past 12 months**?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 6)**

5A. During the **past 12 months**, did you consult with a healthcare professional because of problems you had with pain?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 6)**

5B. During the **past 12 months**, how many times did you consult with a healthcare professional because of problems you had with pain?

_______ Times

5C. What type of healthcare professional did you consult with about your pain?

| **Yes** | **No** | |
|---|---|---|
| ❑ 1 | ❑ 2 | Medical doctor |
| ❑ 1 | ❑ 2 | Nurse |
| ❑ 1 | ❑ 2 | Nurse practitioner |
| ❑ 1 | ❑ 2 | Physician assistant |
| ❑ 1 | ❑ 2 | Osteopath |
| ❑ 1 | ❑ 2 | Chiropractor |
| ❑ 1 | ❑ 2 | Psychologist |
| ❑ 1 | ❑ 2 | Healer |
| ❑ 1 | ❑ 2 | Others, specify: _______________________ |

_______________________________________

_______________________________________

_______________________________________

5D. What did the healthcare professional(s) tell you was the reason for your problems with pain? Please list all reasons.

_______________________________________________________

_______________________________________________________

_______________________________________________________

_______________________________________________________

6. During the **past 12 months**, have you wanted to or thought that you should consult a healthcare professional but did not?

❑ 1 Yes

❑ 2 No **(SKIP TO 8)**

7. In the grid below, please provide the following information for each time you thought you should consult with a healthcare professional but did not:

7A. Reason for wanting to consult with a healthcare professional.

7B. Reason for not consulting with a healthcare professional.

| | **7A. Reason for wanting to consult with a healthcare professional.** | **7B. Reason for not consulting with a healthcare professional.** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

8. Is there a place that you **usually** go to when you are sick or need advice about your health?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 9)**

8a. What kind of place do you usually go to when you are sick or need advice about your health?

| Yes | No | |
|---|---|---|
| ❑ 1 | ❑ 2 | Clinic or health center |
| ❑ 1 | ❑ 2 | Doctor's office or Health Maintenance Organization |
| ❑ 1 | ❑ 2 | Hospital emergency room |
| ❑ 1 | ❑ 2 | Hospital outpatient department |
| ❑ 1 | ❑ 2 | Some other place, specify: ________________ |

________________________________________

________________________________________

________________________________________

9. During the **past 12 months,** did you change the place(s) to which you **usually** go for healthcare?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 10)**

9a. Please explain why you changed where you **usually** go for healthcare.

________________________________________

________________________________________

________________________________________

________________________________________

10. During the **past 12 months,** did a home healthcare provider visit you at home for any reason related to your personal health?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 11)**

10a. How many home healthcare visits did you have?

_______ Visits

11. During the **past 12 months**, did you make any visits to a dentist or other dental professional, such as a hygienist, orthodontist, or oral surgeon?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 12)**

11A. How many visits to the dentist or other dental professional did you make?

_______ Visits

12. During the **past 12 months**, did you stay overnight in the hospital for any reason related to your personal health?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 14)**

13. Please provide the following information for each overnight hospital stay you had during the past 12 months:

A. Health conditions or injuries related to your hospital stay.
B. Procedures, tests, or treatments you received during your hospital stay.
C. Number of nights you stayed in the hospital.

| | **A.**<br><br>Health conditions or injuries related to your hospital stay | **B.**<br><br>Procedures, tests, or treatments you received during your hospital stay | **C.**<br><br>Number of nights in the hospital |
|---|---|---|---|
| **STAY #1** | | ❑ 1 Operation or Surgical Procedure<br>❑ 2 Treatment or therapy, not including surgery<br>❑ 3 Diagnostic tests only<br>❑ 4 Childbirth<br>❑ 5 Other (Specify below)<br>____________________ | ________ |
| **STAY #2** | | ❑ 1 Operation or Surgical Procedure<br>❑ 2 Treatment or therapy, not including surgery<br>❑ 3 Diagnostic tests only<br>❑ 4 Childbirth<br>❑ 5 Other (Specify below)<br>____________________ | ________ |
| **STAY #3** | | ❑ 1 Operation or Surgical Procedure<br>❑ 2 Treatment or therapy, not including surgery<br>❑ 3 Diagnostic tests only<br>❑ 4 Childbirth<br>❑ 5 Other (Specify below)<br>____________________ | ________ |

**NOTE:** If you have had more than three hospital stays within the past 12 months, please record the applicable information about those hospital stays on the back of this page.

**In the next questions, we would like to know more about visits you may have made to different healthcare providers.**

14. Not including hospital stays, please answer the following questions about each type of healthcare provider you visited during *the past 12 months*.

    A. During *the past 12 months*, did you visit this type of healthcare provider?

    B. (If "Yes" to A.) During *the past 12 months*, how many visits to this type of healthcare provider did you make?

**If "Yes" to Question A, Answer Question B**

| | A.<br>During *the past 12 months*, did you visit this type of healthcare provider?<br>**YES** | <br><br><br>**NO** | B.<br>During *the past 12 months*, how many visits to this type of healthcare provider did you make? |
|---|---|---|---|
| **Doctor (physician or osteopath)** | ❑ 1 | ❑ 2 | Number of Visits: ___________ |
| **Nurse or paramedical (such as physician's assistant, dental hygienist, etc.)** | ❑ 1 | ❑ 2 | Number of Visits: ___________ |
| **Psychiatrist, psychologist, or counselor** | ❑ 1 | ❑ 2 | Number of Visits: ___________ |
| **Other healthcare professional (specify below)**<br>______________________________ | ❑ 1 | ❑ 2 | Number of Visits: ___________ |
| **Other healthcare professional (specify below)**<br>______________________________ | ❑ 1 | ❑ 2 | Number of Visits: ___________ |
| **Other healthcare professional (specify below)**<br>______________________________ | ❑ 1 | ❑ 2 | Number of Visits: ___________ |

**In the next questions, we would like to know more about treatments you may have received from different healthcare professionals.**

15. During the **past 12 months**, have you been treated by a medical doctor or doctor of osteopathic medicine? Please do not include chiropractors or other non-medical doctors.

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 16)**

15A. For what condition or health problem were you treated by a medical doctor or doctor of osteopathic medicine?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

15B. In general, how much did the treatment by a medical doctor or doctor of osteopathic medicine help you?

- ❑ 1 Not at all
- ❑ 2 Some
- ❑ 3 A lot
- ❑ 4 Can't tell

16. During the **past 12 months**, have you been treated by a chiropractor?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 17)**

16A. For what condition or health problem were you treated by a chiropractor?

______________________________________________

______________________________________________

______________________________________________

______________________________________________

16B. In general, how much did the treatment by a chiropractor help you?

- ❑ 1 Not at all
- ❑ 2 Some
- ❑ 3 A lot
- ❑ 4 Can't tell

17. During the **past 12 months**, have you been treated by a massage therapist?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 18)**

17A. For what condition or health problem were you treated by a massage therapist?

______________________________________________

______________________________________________

______________________________________________

______________________________________________

17B. In general, how much did the treatment by a massage therapist help you?

- ❑ 1 Not at all
- ❑ 2 Some
- ❑ 3 A lot
- ❑ 4 Can't tell

**The next questions are about chronic fatigue syndrome.**

18. Have you ever been diagnosed with chronic fatigue syndrome (CFS)?

- ☐ 1 Yes
- ☐ 2 No **(SKIP TO 19)**

18A. Who diagnosed you with chronic fatigue syndrome (CFS)?

| Yes | No | |
|---|---|---|
| ☐ 1 | ☐ 2 | Medical doctor |
| ☐ 1 | ☐ 2 | Nurse |
| ☐ 1 | ☐ 2 | Nurse practitioner |
| ☐ 1 | ☐ 2 | Physician assistant |
| ☐ 1 | ☐ 2 | Osteopath |
| ☐ 1 | ☐ 2 | Chiropractor |
| ☐ 1 | ☐ 2 | Psychologist |
| ☐ 1 | ☐ 2 | Healer |
| ☐ 1 | ☐ 2 | Others, specify: ____________________ |

______________________________

______________________________

______________________________

18B. Did the person who diagnosed you with CFS give you any materials, such as a patient brochure on CFS or education materials?

- ☐ 1 Yes
- ☐ 2 No **(SKIP TO 18D)**

18C. What types of materials were you given?

______________________________

______________________________

______________________________

______________________________

18D. Did the person who diagnosed you with CFS give you a referral to another healthcare provider or specialist?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 18F)**

18E. To what type of healthcare provider or specialist were you referred?

______________________________________________________________________

______________________________________________________________________

18F. Have you ever joined a support group for chronic fatigue syndrome (CFS)?

- ❑ 1 Yes
- ❑ 2 No **(SKIP TO 19)**

The next questions are about treatments, techniques, or supplements you may have used. For each of these treatments, techniques, or supplements, please answer the following questions:

A. In the **past 12 months**, did you use this treatment, technique, or supplement?
B. If yes, for what condition or health problem did you use it?
C. How much did the treatment, technique, or supplement help you?

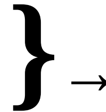
| | A. In the **past 12 months,** did you use this treatment, technique, or supplement? | B. IF YES: For what condition or health problem did you use it? | C. How much did it help you? |
|---|---|---|---|
| 19. Spiritual healing or prayer by others for health reasons | ❑ Yes<br>❑ No → GO TO 20 | | ❑ Not at all<br>❑ Some<br>❑ A lot<br>❑ Can't tell |
| 20. Personal prayer for health reasons | ❑ Yes<br>❑ No → GO TO 21 | | ❑ Not at all<br>❑ Some<br>❑ A lot<br>❑ Can't tell |
| 21. Mindful-exercise, such as yoga or tai chi | ❑ Yes<br>❑ No → GO TO 22 | | ❑ Not at all<br>❑ Some<br>❑ A lot<br>❑ Can't tell |
| 22. A group meeting where people with similar health problems got together to support and help each other | ❑ Yes<br>❑ No → GO TO 23 | | ❑ Not at all<br>❑ Some<br>❑ A lot<br>❑ Can't tell |

| | A. In the **past 12 months,** did you use this treatment, technique, or supplement? | B. IF YES: For what condition or health problem did you use it? | C. How much did it help you? |
|---|---|---|---|
| 23. Energy healing, such as magnets, crystals and energy emitting machines | ❑ Yes<br>❑ No → GO TO 24 | | ❑ Not at all<br>❑ Some<br>❑ A lot<br>❑ Can't tell |
| 24. Biofeedback | ❑ Yes<br>❑ No → GO TO 25 | | ❑ Not at all<br>❑ Some<br>❑ A lot<br>❑ Can't tell |
| 25. Hypnosis | ❑ Yes<br>❑ No → GO TO 26 | | ❑ Not at all<br>❑ Some<br>❑ A lot<br>❑ Can't tell |
| 26. Imagery or visualization | ❑ Yes<br>❑ No → GO TO 27 | | ❑ Not at all<br>❑ Some<br>❑ A lot<br>❑ Can't tell |
| 27. Acupuncture | ❑ Yes<br>❑ No → GO TO 28 | | ❑ Not at all<br>❑ Some<br>❑ A lot<br>❑ Can't tell |

| | A. In the **past 12 months,** did you use this treatment, technique, or supplement? | B. IF YES: For what condition or health problem did you use it? | C. How much did it help you? |
|---|---|---|---|
| 28. Commercial dietary supplements (these include daily vitamins or supplements that serve as a source of vitamins) | ❑ Yes<br>❑ No → GO TO 29 | | ❑ Not at all<br>❑ Some<br>❑ A lot<br>❑ Can't tell |
| 29. Herbal or botanical supplements such as ginseng, garlic, gingko biloba, echinacea, St John's wort or saw palmetto | ❑ Yes<br>❑ No → GO TO 30 | | ❑ Not at all<br>❑ Some<br>❑ A lot<br>❑ Can't tell |

30. Did you discuss your use of these treatments, techniques or supplements in items 19 through 29 above with your doctor?

❑ 1 Yes
❑ 2 Some yes, some no
❑ 3 No
❑ 4 I don't have a doctor
❑ 5 I didn't use any of these treatments, techniques, or supplements



**Go to Box A on page 19**

31. Are you using these treatments, techniques, or supplements to treat an illness or disease?

❑ 1 Yes
❑ 2 No

32. Are you using these treatments techniques, or supplements to prevent an illness or disease?

- ❑ 1 Yes
- ❑ 2 No

**CONTINUE ON THE NEXT PAGE**

**BOX A**

**SENSE OF COMMUNITY**

**The next part of this survey includes statements that people might make about their neighborhood.**

**If you live in a city or town, your neighborhood is your block. It includes all the buildings or houses on your street with numbers in the same range of 100. For example, if your address is 109 Maple Avenue, your neighborhood includes all the buildings and houses with an address between 100 and 199 Maple Avenue.**

**If you live in the country, your neighborhood is a 1-mile block.**

**For each statement, please mark whether it is mostly true or mostly false about your neighborhood.**

| | **Mostly True** | **Mostly False** |
|---|---|---|
| 33. I think my neighborhood is a good place for me to live. | ☐ 1 | ☐ 2 |
| 34. People in this neighborhood do not share the same values. | ☐ 1 | ☐ 2 |
| 35. My neighbors and I want the same things from the neighborhood. | ☐ 1 | ☐ 2 |
| 36. I can recognize most of the people who live in my neighborhood. | ☐ 1 | ☐ 2 |
| 37. I feel at home in this neighborhood. | ☐ 1 | ☐ 2 |
| 38. Very few of my neighbors know me. | ☐ 1 | ☐ 2 |
| 39. I care about what my neighbors think of my actions. | ☐ 1 | ☐ 2 |
| 40. I have no influence over what this neighborhood is like. | ☐ 1 | ☐ 2 |
| 41. If there is a problem in this neighborhood, people who live here can get it solved. | ☐ 1 | ☐ 2 |
| 42. It is very important to me to live in this particular neighborhood. | ☐ 1 | ☐ 2 |
| 43. People in this neighborhood generally don't get along with each other. | ☐ 1 | ☐ 2 |
| 44. I expect to live in this neighborhood for a long time. | ☐ 1 | ☐ 2 |

45. How long have you lived in your neighborhood?

- ❑ Less than one year **(END OF QUESTIONNAIRE – THANK YOU!)**
- ❑ One year or longer (**CONTINUE TO 45A)**

45A. How many years have you lived in your neighborhood?

_______ Years

**Thank you.**

**Please bring this to your clinic appointment.**