

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

**Form Approved**  
OMB No. 0920-XXX  
Exp. Date xx/xx/20xx

Public Reporting burden of this collection of information is estimated at 17 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 any 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, GA 30333; Attn: PRA (0920-XXXX).

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



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