



Caregiver Self-Assessment Questionnaire

How are you?

Caregivers are often so concerned with caring for their relative's needs that they lose sight of their own wellbeing. Please take just a moment to answer the following questions. Once you have answered the questions, turn the page to do a self-evaluation.

During the past week or so, I have...

- | | |
|---|---|
| 1. Had trouble keeping my mind on what I was doing <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Been satisfied with the support my family has given me <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Felt that I couldn't leave my relative alone..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Found my relative's living situation to be inconvenient or a barrier to care <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Had difficulty making decisions <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful," please rate your current level of stress. _____ |
| 4. Felt completely overwhelmed..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. On a scale of 1 to 10, with 1 being "very healthy" to 10 being "very ill," please rate your current health compared to what it was this time last year. _____ |
| 5. Felt useful and needed <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 6. Felt lonely <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 7. Been upset that my relative has changed so much from his/her former self..... <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 8. Felt a loss of privacy and/or personal time <input type="checkbox"/> Yes <input type="checkbox"/> No | Comments:
(Please feel free to comment or provide feedback) |
| 9. Been edgy or irritable <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 10. Had sleep disturbed because of caring for my relative <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 11. Had a crying spell(s) <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 12. Felt strained between work and family responsibilities..... <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 13. Had back pain <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 14. Felt ill (<i>headaches, stomach problems or common cold</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

