## INSTRUCTIONS

This questionnaire is a part of The Irish Longitudinal Study on Ageing (TILDA). We greatly value your participation in our study, and we hope that you will find this questionnaire interesting to complete. Your answers are extremely important to us. Please remember that your participation is voluntary and that you may skip over any questions that you would prefer not to answer.

## HOW TO FILL IN THIS QUESTIONNAIRE

Please answer the questions by:

Ticking a box like this ☑

Or circling an answer like this 1 2 (3) 4 5

Or writing a number in a box like this 3

Sometimes you will find an instruction telling you which questions to answer next, like this

YES ☐

NO ☑ IF 'NO' GO TO QUESTION 3

## HOW TO RETURN THIS QUESTIONNAIRE

**Please give the questionnaire to the interviewer or post it back in the prepaid envelope provided.**

**If you have any questions about the questionnaire, please feel free to call us at 01 896 2509.**

## PLEASE ANSWER ALL QUESTIONS BASED ON THE PRESENT MOMENT IN TIME, UNLESS A SPECIFIC TIMEFRAME IS GIVEN.

### 1. WE WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT PARTICIPATION IN SOCIAL ACTIVITIES. HOW OFTEN, IF AT ALL, DO YOU DO ANY OF THE FOLLOWING ACTIVITIES?

| PLEASE TICK ONE BOX PER LINE | DAILY/ ALMOST DAILY | ONCE A WEEK OR MORE | TWICE A MONTH OR MORE | ABOUT ONCE A MONTH | EVERY FEW MONTHS | ABOUT ONCE OR TWICE A YEAR | LESS THAN ONCE A YEAR | NEVER |
|---|---|---|---|---|---|---|---|---|
| Watch television | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Go out to films, plays and concerts | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Attend classes and lectures | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Travel for pleasure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Work in the garden, or your home, or on a car | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Read books or magazines for pleasure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Listen to music, radio | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Spend time on hobbies or creative activities | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Play cards, bingo, games in general | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Go to the pub | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eat out of the house | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Participate in sport activities or exercise | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Visit to or from family or friends, either in person or talking on the phone | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do voluntary work | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## 2. ARE YOU A MEMBER OF ANY OF THESE ORGANISATIONS, CLUBS OR SOCIETIES?

**PLEASE TICK ALL THAT APPLY**

| | |
|---|---|
| Political Party, trade union or environmental groups | ☐ |
| Tenants groups, resident groups, neighbourhood watch | ☐ |
| Church or other religious groups | ☐ |
| Charitable associations | ☐ |
| Education, arts or music groups or evening classes | ☐ |
| Social clubs | ☐ |
| Sports clubs, GAA or gym exercise classes | ☐ |
| Any other organisations, clubs or societies | ☐ |
| None of the above | ☐ |

## 3. WHICH, IF ANY, CLUBS/GROUPS ARE YOU A MEMBER OF?

**PLEASE TICK ALL THAT APPLY**

| | | | |
|---|---|---|---|
| GAA | ☐ | Bridge | ☐ |
| Soccer | ☐ | Dance | ☐ |
| Rugby | ☐ | Art | ☐ |
| Golf | ☐ | Gym | ☐ |
| Tennis | ☐ | Singing (Choir) | ☐ |
| Other (please specify) | ☐ | | |

Specify:

**IN THIS SECTION, WE ARE INTERESTED IN ACTIVE AND PASSIVE PARTICIPATION IN ARTS, CREATIVE AND CULTURAL ACTIVITIES. THESE INCLUDE MUSIC, VISUAL ART, PHOTOGRAPHY, CREATIVE WRITING, POETRY, DANCE, FILM, DRAMA, CRAFTWORK, SINGING, POTTERY, VISITS TO MUSEUMS/GALLERYS/HERITAGE SITES, ETC.**

**ACTIVE PARTICIPATION CAN INVOLVE MAKING, DOING, CREATING, PLAYING, DANCING, WRITING. PASSIVE PARTICIPATION CAN INVOLVE WATCHING, LOOKING AT, LISTENING TO.**

## 4. DO YOU PARTICIPATE IN ANY ARTS, CREATIVE OR CULTURAL ACTIVITIES?

**PLEASE TICK ONE BOX**

- NO, I HAVE NEVER PARTICIPATED ☐
- NO, BUT I HAVE PREVIOUSLY PARTICIPATED ☐
- YES ☐

IF 'NO' GO TO QUESTION 5

IF 'YES' GO TO QUESTION 6

## 5. IF YOU STATED THAT YOU NEVER OR PREVIOUSLY PARTICIPATED IN ARTS, CREATIVE OR CULTURAL ACTIVITIES, WHAT WERE YOUR REASONS FOR NOT PARTICIPATING OR STOPPING YOUR PARTICIPATION?

**PLEASE TICK ALL THAT APPLY**

| | | | |
|---|---|---|---|
| Accessibility issue | ☐ | Cognitive issue | ☐ |
| Cost | ☐ | Lack of transport to venues | ☐ |
| Lack of experience | ☐ | Lack of confidence | ☐ |
| Time/day/duration didn't suit | ☐ | I'm not interested | ☐ |
| Not enough time | ☐ | Nothing available in my area | ☐ |
| Other, please specify | ☐ | | |

Specify:

PLEASE GO TO QUESTION 14

## 6. IF YOU CURRENTLY PARTICIPATE IN ARTS, CREATIVE OR CULTURAL ACTIVITIES, WHAT KIND OF PARTICIPATION IS THIS?

**PLEASE TICK ALL THAT APPLY**

PASSIVE (I.E. WATCHING, LOOKING AT, LISTENING) ☐

ACTIVE (I.E. MAKING, DOING, CREATING, PLAYING, MOVING/DANCING, WRITING) ☐

## 7. WHICH ARTS, CREATIVE OR CULTURAL ACTIVITIES DO YOU PARTICIPATE IN?

**PLEASE TICK ALL THAT APPLY**

| | | | |
|---|---|---|---|
| Playing / listening to / teaching music | ☐ | Visual Art (painting, drawing, collage, textile, etc) | ☐ |
| Photography | ☐ | Literature / Creative Writing / Reading | ☐ |
| Writing / reading poetry | ☐ | Dance | ☐ |
| Film | ☐ | Craftwork (needlework, knitting, crochet, embroidery, cross-stitch, etc) | ☐ |
| Drama / Theatre | ☐ | Visiting museums, gallerys, or heritage sites | ☐ |
| Singing | ☐ | Pottery | ☐ |
| Other (please specify) | ☐ | | |

Specify:

## 8. HOW OFTEN DO YOU PARTICIPATE IN ARTS, CREATIVE OR CULTURAL ACTIVITIES?

| PLEASE TICK ONE BOX | DAILY/ ALMOST DAILY | ONCE A WEEK OR MORE | TWICE A MONTH OR MORE | ABOUT ONCE A MONTH | EVERY FEW MONTHS | ABOUT ONCE OR TWICE A YEAR | LESS THAN ONCE A YEAR |
|---|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## 9. WHERE DO YOU PARTICIPATE IN ARTS, CREATIVE OR CULTURAL ACTIVITIES?

**PLEASE TICK ALL THAT APPLY**

| | | | |
|---|---|---|---|
| Arts Centre | ☐ | Community Centre | ☐ |
| Theatre | ☐ | Cinema | ☐ |
| Hotel | ☐ | Library | ☐ |
| Museum | ☐ | Gallery | ☐ |
| Heritage Site | ☐ | Private home (own or other) | ☐ |
| Online | ☐ | Other, please specify | ☐ |

Specify:

## 10. IF YOU DO NOT CURRENTLY PARTICIPATE IN ARTS, CREATIVE OR CULTURAL ACTIVITIES ONLINE, WOULD YOU PARTICIPATE IF YOU WERE RESOURCED TO DO SO (E.G. PROVIDED WITH MATERIALS, EQUIPMENT, TRAINING)?

**PLEASE TICK ONE BOX**

Yes ☐

No ☐

## 11. WHO DO YOU PARTICIPATE WITH IN ARTS, CREATIVE OR CULTURAL ACTIVITIES?

**PLEASE TICK ALL THAT APPLY**

| | | | |
|---|---|---|---|
| On my own | ☐ | With family / friends on a casual basis | ☐ |
| As part of an organised group | ☐ | Other, please specify | ☐ |

Specify:

## 12. PLEASE CIRCLE A NUMBER FROM 1 TO 10 TO RATE HOW IMPORTANT EACH OF THE FOLLOWING ITEMS ARE IN MOTIVATING YOU TO PARTICIPATE IN ARTS, CREATIVE OR CULTURAL ACTIVITIES.

| PLEASE CIRCLE ONE NUMBER PER LINE | Not important | | | | | | | | | Very important |
|---|---|---|---|---|---|---|---|---|---|---|
| Enjoyment / Fun | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Social aspects / benefits | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Discovery / to learn a new skill | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Autonomy / feeling of independence | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Interest in the activity | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Passion for the arts, creative or cultural activities | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Venue familiarity (accustomed to attending / feel welcome) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Word of mouth - activity was recommended to you | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Having a routine / structured activity to engage in | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Employment opportunities | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## 13. DURING WHICH PERIODS IN YOUR LIFE HAVE YOU PARTICIPATED IN ARTS, CREATIVE OR CULTURAL ACTIVITIES?

**PLEASE TICK ALL THAT APPLY**

| | |
|---|---|
| Young (up to 14 years) | ☐ |
| Young adult (15-24 years) | ☐ |
| Adult (25-44 years) | ☐ |
| Mid-life (45-64 years) | ☐ |
| Older adult (65+ years) | ☐ |

## 14. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR USE OF INFORMATION TECHNOLOGY. WHICH OF THE FOLLOWING DEVICES DO YOU HAVE ACCESS TO IN YOUR HOME?

**PLEASE TICK ALL THAT APPLY**

- Desktop computer ☐
- Laptop computer ☐
- Tablet computer (e.g. iPad, Samsung Galaxy Tab) ☐
- Smartphone (e.g. iPhone, Blackberry) ☐
- TV (e.g. games console or set top box) ☐
- Other mobile devices (that you have access to in the home) ☐

Specify:

## 15. DO YOU HAVE ACCESS TO THE INTERNET?

**PLEASE TICK ALL THAT APPLY**

- I can access it at home ☐
- I can access it elsewhere (friend / relative's house, library, community centre, etc.) ☐
- I have no access to the internet ☐

**IF YOU HAVE 'NO ACCESS' TO THE INTERNET, PLEASE GO TO QUESTION 19**

## 16. ON WHICH OF THE FOLLOWING DEVICES DO YOU ACCESS THE INTERNET?

**PLEASE TICK ALL THAT APPLY**

- Desktop computer ☐
- Laptop computer ☐
- Tablet computer (e.g. iPad, Samsung Galaxy Tab) ☐
- Smartphone (e.g. iPhone, Blackberry) ☐
- TV (e.g. games console or set top box) ☐
- Other mobile devices (please specify) ☐

Specify:

## 17. ON AVERAGE, HOW OFTEN DO YOU USE THE INTERNET OR EMAIL?

**PLEASE TICK ONE BOX**

- Every day, or almost every day ☐
- At least once a week (but not every day) ☐
- At least once a month (but not every week) ☐
- At least once every 3 months ☐
- Never ☐

**IF YOU 'NEVER' ACCESS THE INTERNET OR EMAIL, PLEASE GO TO QUESTION 19**

## 18. FOR WHICH OF THE FOLLOWING ACTIVITIES DID YOU USE THE INTERNET IN THE LAST 3 MONTHS?

**PLEASE TICK ALL THAT APPLY**

| | |
|---|---|
| Sending / receiving e-mails | ☐ |
| Telephoning or using video calls (via webcam) over the internet to stay in contact with family or friends (e.g. Skype) | ☐ |
| Searching for information for learning, research, fact finding | ☐ |
| Financial transactions (e.g. online shopping, buying or selling goods or services, banking, paying bills, bookings flights) | ☐ |
| Using social networking sites (e.g. Facebook, Twitter, Myspace) | ☐ |
| News / newspaper / blog websites | ☐ |
| Gaming/Apps | ☐ |
| Other (please specify) | ☐ |

Specify:

## 19. DO YOU SOMETIMES FEEL AS IF YOU ARE OUTSIDE OF SOCIETY?

**PLEASE TICK ONE BOX**

- Very often ☐
- Often ☐
- Sometimes ☐
- Hardly ever ☐
- Never ☐

## 20. THE NEXT QUESTIONS ARE ABOUT HOW YOU FEEL ABOUT DIFFERENT ASPECTS OF YOUR LIFE. FOR EACH ONE, PLEASE SAY HOW OFTEN YOU FEEL THAT WAY.

| PLEASE TICK ONE BOX PER LINE | OFTEN | SOME OF THE TIME | HARDLY EVER OR NEVER |
|---|---|---|---|
| How often do you feel you lack companionship? | ☐ | ☐ | ☐ |
| How often do you feel left out? | ☐ | ☐ | ☐ |
| How often do you feel isolated from others? | ☐ | ☐ | ☐ |
| How often do you feel in tune with the people around you? | ☐ | ☐ | ☐ |
| How often do you feel lonely? | ☐ | ☐ | ☐ |

## 21. HAVE YOU EXPERIENCED LONELINESS IN OTHER PHASES OF YOUR LIFE?

**PLEASE TICK ONE BOX**

YES ☐

NO ☐ IF 'NO' GO TO QUESTION 24

## 22. WHEN HAVE YOU EXPERIENCED LONELINESS?

**PLEASE TICK ALL THAT APPLY**

- Young (5-14 years) ☐
- Young adult (15-24 years) ☐
- Adult (25-44 years) ☐
- Mid-life (45-64 years) ☐
- Older adult (65+ years) ☐

## 23. IF YOU HAVE EVER EXPERIENCED LONELINESS, HAVE YOU EVER SPOKEN TO ANY OF THE FOLLOWING ABOUT IT?

**PLEASE TICK ALL THAT APPLY**

- GP ☐
- Social Worker ☐
- Psychiatrist ☐
- Nurse ☐
- Counsellor / Psychotherapist ☐
- Other healthcare professional ☐
- Never spoke to a healthcare professional about loneliness ☐

## 24. THE FOLLOWING ARE WAYS PEOPLE REACT TO VARIOUS DIFFICULT, STRESSFUL, OR UPSETTING SITUATIONS. PLEASE CIRCLE A NUMBER FROM 1 TO 5 ON THIS SHEET FOR EACH OF THE FOLLOWING ITEMS. INDICATE HOW MUCH YOU ENGAGE IN THESE TYPES OF ACTIVITIES WHEN YOU ENCOUNTER A DIFFICULT, STRESSFUL, OR UPSETTING SITUATION.

| PLEASE CIRCLE ONE NUMBER PER LINE | NOT AT ALL | | | | VERY MUCH |
|---|---|---|---|---|---|
| Take some time off and get away from the situation | 1 | 2 | 3 | 4 | 5 |
| Focus on the problem and see how I can solve it | 1 | 2 | 3 | 4 | 5 |
| Blame myself for having gotten into this situation | 1 | 2 | 3 | 4 | 5 |
| Treat myself to a favorite food or snack | 1 | 2 | 3 | 4 | 5 |
| Feel anxious about not being able to cope | 1 | 2 | 3 | 4 | 5 |
| Think about how I solved similar problems | 1 | 2 | 3 | 4 | 5 |
| Visit a friend | 1 | 2 | 3 | 4 | 5 |
| Determine a course of action and follow it | 1 | 2 | 3 | 4 | 5 |
| Buy myself something | 1 | 2 | 3 | 4 | 5 |
| Blame myself for being too emotional about the situation | 1 | 2 | 3 | 4 | 5 |
| Work to understand the situation | 1 | 2 | 3 | 4 | 5 |
| Become very upset | 1 | 2 | 3 | 4 | 5 |
| Take corrective action immediately | 1 | 2 | 3 | 4 | 5 |
| Blame myself for not knowing what to do | 1 | 2 | 3 | 4 | 5 |
| Spend time with a special person | 1 | 2 | 3 | 4 | 5 |
| Think about the event and learn from my mistakes | 1 | 2 | 3 | 4 | 5 |
| Wish that I could change what had happened or how I felt | 1 | 2 | 3 | 4 | 5 |
| Go out for a snack or meal | 1 | 2 | 3 | 4 | 5 |
| Analyze my problem before reacting | 1 | 2 | 3 | 4 | 5 |
| Focus on my general inadequacies | 1 | 2 | 3 | 4 | 5 |
| Phone a friend | 1 | 2 | 3 | 4 | 5 |

## 25. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR SPOUSE OR PARTNER WITH WHOM YOU LIVE.

**IF YOU DO NOT HAVE A HUSBAND, WIFE OR PARTNER WITH WHOM YOU LIVE, PLEASE GO TO QUESTION 27**

| PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT | A LOT | SOME | A LITTLE | NOT AT ALL |
|---|---|---|---|---|
| How much does he/she really understand the way you feel about things? | ☐ | ☐ | ☐ | ☐ |
| How much can you rely on him/her if you have a serious problem? | ☐ | ☐ | ☐ | ☐ |
| How much can you open up to him/her if you need to talk about your worries? | ☐ | ☐ | ☐ | ☐ |
| How much does he/she make too many demands on you? | ☐ | ☐ | ☐ | ☐ |
| How much does he/she criticise you? | ☐ | ☐ | ☐ | ☐ |
| How much does he/she let you down when you are counting on him/her? | ☐ | ☐ | ☐ | ☐ |
| How much does he/she get on your nerves? | ☐ | ☐ | ☐ | ☐ |

## 26. HOW CLOSE IS YOUR RELATIONSHIP WITH YOUR SPOUSE OR PARTNER WITH WHOM YOU LIVE?

**PLEASE TICK ONE BOX**

- ☐ Very close
- ☐ Quite close
- ☐ Not very close
- ☐ Not at all close

## 27. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR CHILDREN.

**IF YOU DO NOT HAVE CHILDREN, PLEASE GO TO QUESTION 28**

| PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT | A LOT | SOME | A LITTLE | NOT AT ALL |
|---|---|---|---|---|
| How much do they really understand the way you feel about things? | ☐ | ☐ | ☐ | ☐ |
| How much can you rely on them if you have a serious problem? | ☐ | ☐ | ☐ | ☐ |
| How much can you open up to them if you need to talk about your worries? | ☐ | ☐ | ☐ | ☐ |
| How much do they make too many demands on you? | ☐ | ☐ | ☐ | ☐ |
| How much do they criticise you? | ☐ | ☐ | ☐ | ☐ |
| How much do they let you down when you are counting on them? | ☐ | ☐ | ☐ | ☐ |
| How much do they get on your nerves? | ☐ | ☐ | ☐ | ☐ |

## 28. APART FROM YOUR SPOUSE / PARTNER AND CHILDREN (IF ANY), DO YOU HAVE ANY OTHER FAMILY MEMBERS (SUCH AS BROTHERS, SISTERS, PARENTS, COUSINS, ETC.)?

**PLEASE TICK ONE BOX**

YES ☐

NO ☐ IF 'NO' GO TO QUESTION 30

## 29. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT THESE FAMILY MEMBERS.

| PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT | A LOT | SOME | A LITTLE | NOT AT ALL |
|---|---|---|---|---|
| How much do they really understand the way you feel about things? | ☐ | ☐ | ☐ | ☐ |
| How much can you rely on them if you have a serious problem? | ☐ | ☐ | ☐ | ☐ |
| How much can you open up to them if you need to talk about your worries? | ☐ | ☐ | ☐ | ☐ |
| How much do they make too many demands on you? | ☐ | ☐ | ☐ | ☐ |
| How much do they criticise you? | ☐ | ☐ | ☐ | ☐ |
| How much do they let you down when you are counting on them? | ☐ | ☐ | ☐ | ☐ |
| How much do they get on your nerves? | ☐ | ☐ | ☐ | ☐ |

## 30. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR FRIENDS.

| PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT | A LOT | SOME | A LITTLE | NOT AT ALL |
|---|---|---|---|---|
| How much do they really understand the way you feel about things? | ☐ | ☐ | ☐ | ☐ |
| How much can you rely on them if you have a serious problem? | ☐ | ☐ | ☐ | ☐ |
| How much can you open up to them if you need to talk about your worries? | ☐ | ☐ | ☐ | ☐ |
| How much do they make too many demands on you? | ☐ | ☐ | ☐ | ☐ |
| How much do they criticise you? | ☐ | ☐ | ☐ | ☐ |
| How much do they let you down when you are counting on them? | ☐ | ☐ | ☐ | ☐ |
| How much do they get on your nerves? | ☐ | ☐ | ☐ | ☐ |

## 31. FOR SOME PEOPLE, SEX IS A VERY IMPORTANT PART OF THEIR LIVES AND FOR OTHERS, IT IS NOT VERY IMPORTANT AT ALL. HOW IMPORTANT A PART OF YOUR LIFE, WOULD YOU SAY THAT SEX IS?

**PLEASE TICK ONE BOX**

- Extremely important ☐
- Very important ☐
- Moderately important ☐
- Somewhat important ☐
- Not at all important ☐

## 32. ARE YOU CURRENTLY SEXUALLY ACTIVE (WITHIN THE LAST 12 MONTHS)?

**PLEASE TICK ONE BOX**

- YES ☐
- NO ☐ IF 'NO' GO TO QUESTION 34

## 33. HOW OFTEN DO YOU ENGAGE IN SEXUAL ACTIVITY?

**PLEASE TICK ONE BOX**

- Every day ☐
- Once or twice a week ☐
- Once or twice a month ☐
- Every few months ☐
- Once or twice a year ☐

## 34. THE NEXT QUESTION IS RELATED TO YOUR SEXUAL ORIENTATION. THIS DESCRIBES WHO YOU ARE SEXUALLY AND EMOTIONALLY ATTRACTED TO.

**PLEASE TICK ONE BOX**

Heterosexual – sexually and romantically attracted to the opposite sex only ☐

Homosexual (gay or lesbian) – sexually and romantically attracted to the same sex only ☐

Bisexual – sexually and romantically attracted to both the same and opposite sex ☐

Asexual – not sexually and romantically attracted to either sex ☐

Other (please specify) ☐

Specify:

## 35. WE WOULD LIKE TO ASK SOME QUESTIONS ABOUT HOW CONCERNED YOU ARE ABOUT THE POSSIBILITY OF FALLING. FOR EACH OF THE FOLLOWING ACTIVITIES, PLEASE INDICATE HOW CONCERNED YOU ARE THAT YOU MIGHT FALL IF YOU DID THIS ACTIVITY.

**IF YOU CURRENTLY DON'T DO THE ACTIVITY (E.G. IF SOMEONE DOES YOUR SHOPPING FOR YOU), PLEASE ANSWER TO SHOW WHETHER YOU THINK YOU WOULD BE CONCERNED ABOUT FALLING IF YOU DID THE ACTIVITY**

| PLEASE TICK ONE BOX PER LINE | NOT AT ALL CONCERNED 1 | SOMEWHAT CONCERNED 2 | FAIRLY CONCERNED 3 | VERY CONCERNED 4 |
|---|---|---|---|---|
| Cleaning the house (e.g. sweep, vacuum, dust) | ☐ | ☐ | ☐ | ☐ |
| Getting dressed or undressed | ☐ | ☐ | ☐ | ☐ |
| Preparing simple meal | ☐ | ☐ | ☐ | ☐ |
| Taking a bath or shower | ☐ | ☐ | ☐ | ☐ |
| Going to the shop | ☐ | ☐ | ☐ | ☐ |
| Getting in or out of a chair | ☐ | ☐ | ☐ | ☐ |
| Going up or down stairs | ☐ | ☐ | ☐ | ☐ |
| Walking around in the neighbourhood | ☐ | ☐ | ☐ | ☐ |
| Reaching for something above your head or on the ground | ☐ | ☐ | ☐ | ☐ |
| Going to answer the telephone before it stops ringing | ☐ | ☐ | ☐ | ☐ |
| Walking on a slippery surface (e.g. wet or icy) | ☐ | ☐ | ☐ | ☐ |
| Visiting a friend or relative | ☐ | ☐ | ☐ | ☐ |
| Walking in a place with crowds | ☐ | ☐ | ☐ | ☐ |
| Walking on an uneven surface (e.g. rocky ground, poorly maintained pavement) | ☐ | ☐ | ☐ | ☐ |
| Walking up or down a slope | ☐ | ☐ | ☐ | ☐ |
| Going out to a social event (e.g. religious service, family gathering, or club meeting) | ☐ | ☐ | ☐ | ☐ |

## 36. WE WOULD NOW LIKE TO ASK ABOUT ANY PET / PETS YOU MAY HAVE. DO YOU CURRENTLY HAVE ANY PETS?

**PLEASE TICK ONE BOX**

YES ☐

NO ☐ IF 'NO' GO TO QUESTION 41

## 37. WHAT KIND OF PET / PETS ARE THESE?

**PLEASE TICK ALL THAT APPLY**

| | |
|---|---|
| Dog | ☐ |
| Cat | ☐ |
| Small mammal (rabbit, gerbil, hamster) | ☐ |
| Bird | ☐ |
| Fish | ☐ |
| Other (please specify) | ☐ |

Specify:

## 38. WHAT ARE YOUR REASONS FOR HAVING A PET / PETS?

**PLEASE TICK ALL THAT APPLY**

| | |
|---|---|
| Enjoy (love) animals | ☐ |
| Protection | ☐ |
| Companionship | ☐ |
| Playmate for child | ☐ |
| Want something I could take care of | ☐ |
| Want something to keep me busy (occupy the time) | ☐ |
| Want something to keep me active (get exercise) | ☐ |
| Therapy (e.g. guide dog) | ☐ |
| Was given the pet | ☐ |
| Other (please specify) | ☐ |

Specify:

## 39. THINKING ABOUT THE PET YOU HAVE HAD THE LONGEST, HOW LONG HAVE YOU HAD YOUR PET?

**PLEASE TICK ONE BOX**

- Less than 1 year ☐
- 1-2 years ☐
- 3-5 years ☐
- 6-9 years ☐
- 10+ years ☐

## 40. ON AVERAGE, HOW MANY DAYS PER WEEK DO YOU WALK YOUR DOG?

**IF YOU DO NOT HAVE A DOG, PLEASE GO TO QUESTION 41**

☐ Days per week

## 41. THE NEXT FOUR QUESTIONS ARE ABOUT HOW YOU HAVE FELT IN THE PAST MONTH.

| PLEASE TICK ONE BOX PER LINE | HARDLY EVER | ALMOST NEVER | SOMETIMES | FAIRLY OFTEN | VERY OFTEN |
|---|---|---|---|---|---|
| In the last month, how often have you felt that you were unable to control the important things in your life? | ☐ | ☐ | ☐ | ☐ | ☐ |
| In the last month, how often have you felt confident about your ability to handle your personal problems? | ☐ | ☐ | ☐ | ☐ | ☐ |
| In the last month, how often have you felt that things were going your way? | ☐ | ☐ | ☐ | ☐ | ☐ |
| In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? | ☐ | ☐ | ☐ | ☐ | ☐ |

## WE WOULD NOW LIKE TO ASK YOU ABOUT YOUR TYPICAL SLEEP BEHAVIOUR OVER THE PAST 4 WEEKS. WE ASK ABOUT WORK DAYS AND WORK-FREE DAYS SEPARATELY. PLEASE RESPOND TO THE QUESTIONS ACCORDING TO YOUR PERCEPTION OF A STANDARD WEEK THAT INCLUDES YOUR USUAL WORK DAYS AND WORK-FREE DAYS.

**IF YOU ARE NOT CURRENTLY WORKING, PLEASE GO TO QUESTION 43**

**PLEASE USE 24-HOUR CLOCK (E.G. 4.00PM = 16:00)**

### 42. ON WORK DAYS

I have to get up at _____ o'clock

I need _____ minutes to wake up

I regularly wake up ☐ Before the alarm ☐ After the alarm **PLEASE TICK ONE BOX**

From _____ o'clock, I am fully awake

At around _____ o'clock, I have an energy dip

On nights before work days, I go to bed at _____ o'clock

If I get a chance, I would like to take a siesta / nap ☐ Yes ☐ No **PLEASE TICK ONE BOX**

**IF YES:** I then sleep for _____ minutes

**IF NO:** I would feel terrible afterwards ☐ Yes ☐ No **PLEASE TICK ONE BOX**

## 43. ON WORK-FREE DAYS (PLEASE ONLY JUDGE NORMAL FREE DAYS, I.E. WITHOUT PARTIES, ETC.)

## PLEASE USE 24-HOUR CLOCK (E.G. 4.00PM = 16:00)

My dream would be to sleep until _____ o'clock

I normally wake up at _____ o'clock

If I wake up at around the normal (workday) alarm time, I try to get back to sleep

☐ Correct
☐ Not correct

**PLEASE TICK ONE BOX**

If I get back to sleep, I sleep for another _____ minutes

I need _____ minutes to wake up

From _____ o'clock, I am fully awake

At around _____ o'clock, I have an energy dip

On nights before free days, I go to bed at _____ o'clock

If I get a chance, I would like to take a siesta / nap

☐ Yes
☐ No

**PLEASE TICK ONE BOX**

**IF YES:** I then sleep for _____ minutes

**IF NO:** I would feel terrible afterwards

☐ Yes
☐ No

**PLEASE TICK ONE BOX**

Once I am in bed, I would like to read for _____ minutes

...but generally fall asleep after no more than _____ minutes

I prefer to sleep in a completely dark room

☐ Correct

☐ Not correct

**PLEASE TICK ONE BOX**

I wake up more easily when morning light shines into my room

☐ Correct

☐ Not correct

**PLEASE TICK ONE BOX**

**IN WINTER:** How long do you spend on average outside (really outside) exposed to day light?

On work days: _____ hours _____ minutes

On free days: _____ hours _____ minutes

**IN SUMMER:** How long do you spend on average outside (really outside) exposed to day light?

On work days: _____ hours _____ minutes

On free days: _____ hours _____ minutes

I used:

☐ 12 hour clock

☐ 24 hour clock

**PLEASE TICK ONE BOX**

## 44. HERE IS A LIST OF STATEMENTS THAT PEOPLE HAVE USED TO DESCRIBE THEIR LIVES OR HOW THEY FEEL. HOW OFTEN DO YOU FEEL LIKE THIS?

| PLEASE TICK ONE BOX PER LINE | OFTEN | SOMETIMES | RARELY | NEVER |
|---|---|---|---|---|
| My age prevents me from doing the things I would like to | ☐ | ☐ | ☐ | ☐ |
| I feel that what happens to me is out of my control | ☐ | ☐ | ☐ | ☐ |
| I feel free to plan for the future | ☐ | ☐ | ☐ | ☐ |
| I feel left out of things | ☐ | ☐ | ☐ | ☐ |
| I feel that I can please myself in what I can do | ☐ | ☐ | ☐ | ☐ |
| My health stops me from doing the things I want to do | ☐ | ☐ | ☐ | ☐ |
| Shortage of money stops me from doing the things that I want to do | ☐ | ☐ | ☐ | ☐ |
| I look forward to each day | ☐ | ☐ | ☐ | ☐ |
| I feel that my life has meaning | ☐ | ☐ | ☐ | ☐ |
| I enjoy being in the company of others | ☐ | ☐ | ☐ | ☐ |
| I feel satisfied with the way my life has turned out | ☐ | ☐ | ☐ | ☐ |
| I feel that life is full of opportunities | ☐ | ☐ | ☐ | ☐ |

## 45. HAVE YOU EVER HAD DRINKS CONTAINING ALCOHOL, E.G. GLASS OF WINE, GLASS OF BEER, ETC.?

**PLEASE TICK ONE BOX**

YES ☐

NO ☐ IF 'NO' GO TO QUESTION 55

## 46. HAVE YOU HAD DRINKS CONTAINING ALCOHOL OF ANY KIND IN THE LAST 6 MONTHS?

**PLEASE TICK ONE BOX**

YES ☐

NO ☐ IF 'NO' GO TO QUESTION 55

## 47. DURING THE LAST 6 MONTHS, HOW OFTEN HAVE YOU HAD DRINKS CONTAINING ALCOHOL, LIKE BEER, CIDER, WINE, SPIRITS OR COCKTAILS?

**PLEASE TICK ONE BOX**

Daily ☐

4-6 days a week ☐

2-3 days a week ☐

Once a week ☐

2-3 days a month ☐

Once a month ☐

One or a couple of days per year ☐ GO TO QUESTION 49

## 48. MORE RECENTLY (I.E. IN THE LAST MONTH), WOULD YOU DESCRIBE YOUR CURRENT ALCOHOL INTAKE AS:

**PLEASE TICK ONE BOX**

Daily ☐

4-6 days a week ☐

2-3 days a week ☐

Once a week ☐

2-3 days a month ☐

Once a month ☐

## 49. HAVE YOU EVER FELT THAT YOU SHOULD CUT DOWN ON DRINKING?

**PLEASE TICK ONE BOX**

YES ☐

NO ☐

## 50. HAVE YOU REDUCED YOUR ALCOHOL INTAKE IN THE LAST 2 YEARS?

**PLEASE TICK ONE BOX**

YES ☐

NO ☐ IF 'NO' GO TO QUESTION 52

## 51. WHY DID YOU REDUCE YOUR ALCOHOL INTAKE?

**PLEASE TICK ONE BOX**

Personal choice ☐

Doctor's advice ☐

Medication ☐

Illness or ill health ☐

Other reasons (please specify) ☐

## 52. HAVE PEOPLE EVER ANNOYED YOU BY CRITICISING YOUR DRINKING?

**PLEASE TICK ONE BOX**

YES ☐

NO ☐

## 53. HAVE YOU EVER FELT BAD OR GUILTY ABOUT DRINKING?

**PLEASE TICK ONE BOX**

YES ☐

NO ☐

## 54. HAVE YOU EVER TAKEN A DRINK FIRST THING IN THE MORNING TO STEADY YOUR NERVES OR GET RID OF A HANGOVER?

**PLEASE TICK ONE BOX**

YES ☐

NO ☐

## 55. HOW MANY PORTIONS OF FRUIT – OF ANY KIND – DO YOU EAT ON A TYPICAL DAY? IF NONE, PLEASE ENTER '0'.

**A PORTION OF FRUIT IS AN APPLE OR BANANA, A SMALL BOWL OF GRAPES, OR THREE TABLESPOONS OF TINNED OR STEWED FRUIT. IF YOU DRINK FRUIT JUICE, YOU CAN COUNT ONE GLASS PER DAY, BUT ADDITIONAL GLASSES OF FRUIT JUICE DO NOT COUNT AS ADDITIONAL PORTIONS**

_____ PORTIONS

## 56. HOW MANY PORTIONS OF VEGETABLES – EXCLUDING POTATOES – DO YOU EAT ON A TYPICAL DAY? IF NONE, PLEASE ENTER '0'.

**A SERVING OR PORTION OF VEGETABLES MEANS THREE HEAPED TABLESPOONS OF GREEN OR ROOT VEGETABLES SUCH AS CARROTS, PARSNIPS, SPINACH, SMALL VEGETABLES LIKE PEAS, BAKED BEANS OR SWEET CORN, OR A MEDIUM BOWL OF SALAD (LETTUCE, TOMATOES, ETC.)**

_____ PORTIONS

## 57. FOR EACH OF THE FOLLOWING EVENTS, PLEASE INDICATE WHETHER THE EVENT OCCURRED AT ANY POINT IN YOUR LIFE. IF THE EVENT DID HAPPEN, PLEASE INDICATE THE YEAR IN WHICH IT HAPPENED MOST RECENTLY.

| PLEASE TICK ONE BOX PER LINE | YES | NO | If Yes, in what year did this occur last? |
|---|---|---|---|
| Have you ever been in a major fire, flood or other natural disaster? | ☐ | ☐ | |
| Has your spouse, partner, or child ever been addicted to drugs or alcohol? | ☐ | ☐ | |
| Were you the victim of a serious physical attack or assault in your life? | ☐ | ☐ | |
| Did you ever have a life-threatening illness or accident? | ☐ | ☐ | |
| Did your spouse, partner, or a child of yours ever have a life-threatening illness or accident? | ☐ | ☐ | |
| Has a child of yours ever died? | ☐ | ☐ | |
| Before you were 17 years old, did you have to repeat a year of school over again? | ☐ | ☐ | |
| Before you were 18 years old, did either of your parents drink or use drugs so often that it caused problems in the family? | ☐ | ☐ | |
| Before you were 18 years old, were you ever physically abused by either of your parents? | ☐ | ☐ | |
| Before you were 18 years old, were you ever sexually abused by either of your parents? | ☐ | ☐ | |
| Before you were 18 years old, were you ever sexually abused by another other than your parents? | ☐ | ☐ | |

## THINK ABOUT THE DIFFERENT FACILITIES IN AND AROUND YOUR NEIGHBOURHOOD. BY THIS, WE MEAN THE AREA ALL AROUND YOUR HOME THAT YOU COULD WALK TO IN 10-15 MINUTES.

### 58. WHAT IS THE MAIN TYPE OF HOUSING IN YOUR NEIGHBOURHOOD?

**PLEASE TICK ALL THAT APPLY**

- Detached single-family housing ☐
- Townhouses, row houses, apartments, or condos of 2-3 stories ☐
- Mix of single-family residences and townhouses, row houses, apartments or condos ☐
- Apartments or condos of 4-12 stories ☐
- Apartments or condos of more than 12 stories ☐

## THE NEXT ITEMS ARE STATEMENTS ABOUT YOUR NEIGHBOURHOOD RELATED TO WALKING AND BICYCLING.

### 59. MANY SHOPS, STORES, MARKETS OR OTHER PLACES TO BUY THINGS I NEED ARE WITHIN EASY WALKING DISTANCE OF MY HOME. WOULD YOU SAY THAT YOU…

**PLEASE TICK ONE BOX**

- Strongly Disagree ☐
- Somewhat Disagree ☐
- Somewhat Agree ☐
- Strongly Agree ☐
- Don’t Know/Not Sure ☐

### 60. IT IS WITHIN A 10-15 MINUTE WALK TO A TRANSIT STOP (SUCH AS BUS, TRAIN, TROLLEY, OR TRAM) FROM MY HOME. WOULD YOU SAY THAT YOU…

**PLEASE TICK ONE BOX**

- Strongly Disagree ☐
- Somewhat Disagree ☐
- Somewhat Agree ☐
- Strongly Agree ☐
- Don’t Know/Not Sure ☐

## 61. THERE ARE SIDEWALKS ON MOST OF THE STREETS IN MY NEIGHBORHOOD. WOULD YOU SAY THAT YOU…

**PLEASE TICK ONE BOX**

- Strongly Disagree ☐
- Somewhat Disagree ☐
- Somewhat Agree ☐
- Strongly Agree ☐
- Does not apply to my neighbourhood ☐
- Don’t Know/Not Sure ☐

## 62. THERE ARE FACILITIES TO BICYCLE IN OR NEAR MY NEIGHBORHOOD, SUCH AS SPECIAL LANES, SEPARATE PATHS OR TRAILS, SHARED USE PATHS FOR CYCLES AND PEDESTRIANS. WOULD YOU SAY THAT YOU…

**PLEASE TICK ONE BOX**

- Strongly Disagree ☐
- Somewhat Disagree ☐
- Somewhat Agree ☐
- Strongly Agree ☐
- Does not apply to my neighbourhood ☐
- Don’t Know/Not Sure ☐

## 63. MY NEIGHBORHOOD HAS SEVERAL FREE OR LOW COST RECREATION FACILITIES, SUCH AS PARKS, WALKING TRAILS, BIKE PATHS, RECREATION CENTERS, PLAYGROUNDS, PUBLIC SWIMMING POOLS, ETC. WOULD YOU SAY THAT YOU…

**PLEASE TICK ONE BOX**

- Strongly Disagree ☐
- Somewhat Disagree ☐
- Somewhat Agree ☐
- Strongly Agree ☐
- Does not apply to my neighbourhood ☐
- Don’t Know/Not Sure ☐

## 64. THE CRIME RATE IN MY NEIGHBORHOOD MAKES IT UNSAFE TO GO ON WALKS AT NIGHT. WOULD YOU SAY THAT YOU…

**PLEASE TICK ONE BOX**

- Strongly Disagree ☐
- Somewhat Disagree ☐
- Somewhat Agree ☐
- Strongly Agree ☐
- Don't Know/Not Sure ☐

## 65. IN THE PAST TWO YEARS, HAVE YOU PERSONALLY FELT DISCRIMINATED AGAINST BECAUSE OF YOUR AGE IN ANY OF THE FOLLOWING SITUATIONS?

| PLEASE TICK ONE BOX PER LINE | YES | NO | NOT APPLICABLE | DON'T KNOW |
|---|---|---|---|---|
| The workplace? | ☐ | ☐ | ☐ | ☐ |
| While looking for work? | ☐ | ☐ | ☐ | ☐ |
| In places such as shops, pubs or restaurants? | ☐ | ☐ | ☐ | ☐ |
| Using services of banks, insurance companies or other financial institutes? | ☐ | ☐ | ☐ | ☐ |
| In relation to education? | ☐ | ☐ | ☐ | ☐ |
| While you were looking for housing or accommodation? | ☐ | ☐ | ☐ | ☐ |
| While accessing health services (e.g. getting access to a GP, access to hospital, access to specialist treatment)? | ☐ | ☐ | ☐ | ☐ |
| Using transport services? | ☐ | ☐ | ☐ | ☐ |
| Accessing other public services either at a local or national level? | ☐ | ☐ | ☐ | ☐ |

## 66. WE WOULD NOW LIKE TO ASK SOME QUESTIONS ABOUT HOW MUCH YOU WORRY ABOUT THINGS. PLEASE INDICATE HOW TYPICAL OR CHARACTERISTIC EACH STATEMENT IS OF YOU.

| PLEASE TICK ONE BOX PER LINE | NOT AT ALL TYPICAL | | SOMEWHAT TYPICAL | | VERY TYPICAL |
|---|---|---|---|---|---|
| My worries overwhelm me | ☐ | ☐ | ☐ | ☐ | ☐ |
| Many situations make me worry | ☐ | ☐ | ☐ | ☐ | ☐ |
| I know I should not worry about things, but I just cannot help it | ☐ | ☐ | ☐ | ☐ | ☐ |
| When I am under pressure, I worry a lot | ☐ | ☐ | ☐ | ☐ | ☐ |
| I am always worrying about something | ☐ | ☐ | ☐ | ☐ | ☐ |
| As soon as I finish one task, I start to worry about everything else I must do | ☐ | ☐ | ☐ | ☐ | ☐ |
| I have been a worrier all my life | ☐ | ☐ | ☐ | ☐ | ☐ |
| I have been worrying about things | ☐ | ☐ | ☐ | ☐ | ☐ |

## 67. HAVE ANY OF YOUR CLOSE FRIENDS DIED IN THE PAST TWO YEARS? IF SO, WE ARE SORRY TO HEAR THAT.

**PLEASE TICK ONE BOX**

YES ☐

NO ☐

## 68. WHAT IS THE MAIN WAY IN WHICH YOU HEAT YOUR ACCOMMODATION IN THE WINTER?

**PLEASE TICK ONE BOX**

Central heating ☐

Open fire only ☐

Portable heaters only ☐

Open fire and portable heaters ☐

Closed solid fuel appliance only ☐

Closed solid fuel appliance and portable heaters ☐

## 69. HAVE YOU EVER HAD TO GO WITHOUT HEATING DURING THE LAST 12 MONTHS DUE TO LACK OF MONEY? (I.E. HAVE YOU HAD TO GO WITHOUT A FIRE ON A COLD DAY, OR GO TO BED TO KEEP WARM OR LIGHT THE FIRE LATE BECAUSE OF LACK OF COAL / FUEL)

**PLEASE TICK ONE BOX**

No ☐

Yes - Financial reason ☐

Yes - Home is too big ☐

Yes - Other reason (please specify) ☐

## 70. HOW DO YOU FEEL ABOUT YOUR LOCAL AREA? (THAT IS, EVERYWHERE WITHIN A 20 MINUTE WALK OR ABOUT A KILOMETER OF YOUR HOME)

**THE CLOSER YOUR TICK IS TO A STATEMENT THE MORE STRONGLY YOU AGREE WITH IT.**

**PLEASE TICK ONE BOX EACH LINE**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| I really feel part of this area. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | I feel that I don't belong in this area. |
| Vandalism and graffiti are a big problem in this area. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | There is no problem with vandalism and graffiti in this area. |
| I often feel lonely living in this area. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | I have never felt lonely living in this area. |
| Most people in this area can be trusted. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Most people in this area can't be trusted. |
| People would be afraid to walk alone after dark in this area. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | People feel safe walking alone after dark in this area. |
| Most people in this area are friendly. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Most people in this area are unfriendly. |
| People in this area will take advantage of you. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | People in this area will always treat you fairly. |
| This area is kept very clean. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | The area is always full of litter and rubbish. |
| If you were in trouble, there are lots of people in this area who would help you. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | If you were in trouble, there is nobody in this area who would help you. |

## 71. DID YOU HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS DURING YOUR CHILDHOOD (THAT IS, FROM WHEN YOU WERE BORN UP TO AND INCLUDING AGE 15)?

**PLEASE TICK ONE BOX PER LINE**

| | YES | NO |
|---|---|---|
| Measles | ☐ | ☐ |
| Chicken Pox | ☐ | ☐ |
| Mumps | ☐ | ☐ |
| Polio | ☐ | ☐ |
| Tuberculosis (TB) | ☐ | ☐ |
| Broken Bones | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Allergies other than asthma (e.g. food intolerance, hayfever) | ☐ | ☐ |
| Respiratory problems other than asthma (e.g. bronchitis) | ☐ | ☐ |
| Chronic ear problems | ☐ | ☐ |
| Severe headaches or migraines | ☐ | ☐ |
| Epilepsy, fits or seizures | ☐ | ☐ |
| Emotional, nervous or psychiatric problem | ☐ | ☐ |
| Appendicitis | ☐ | ☐ |
| Childhood diabetes or high blood sugar | ☐ | ☐ |
| Heart trouble | ☐ | ☐ |
| Leukaemia or lymphoma | ☐ | ☐ |
| Cancer or malignant tumour (excluding minor skin cancers) | ☐ | ☐ |

## 72. THINK OF THIS LADDER AS REPRESENTING WHERE PEOPLE STAND IN OUR SOCIETY.

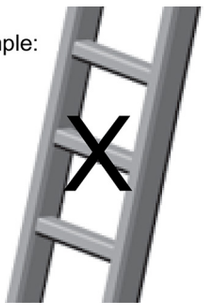
At the top of the ladder are the people who are the best off - those who have the most money, most education and best jobs.

At the bottom are the people who are the worst off - those who have the least money, least education and the worst jobs or no jobs.

The higher up you are on this ladder, the closer you are to the people at the very top and the lower you are, the closer you are to the people at the very bottom.

Please mark a cross on the rung of the ladder where you would place yourself.

Example:



## 73. WE ARE INTERESTED IN YOUR OWN PERSONAL VIEWS AND EXPERIENCES ABOUT GETTING OLDER. PLEASE INDICATE HOW STRONGLY YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS

| PLEASE TICK ONE BOX PER LINE | STRONGLY DISAGREE | DISAGREE | NEITHER AGREE NOR DISAGREE | AGREE | STRONGLY AGREE |
|---|---|---|---|---|---|
| I always classify myself as old | ☐ | ☐ | ☐ | ☐ | ☐ |
| I am always aware of the fact that I am getting older | ☐ | ☐ | ☐ | ☐ | ☐ |
| I feel my age in everything that I do | ☐ | ☐ | ☐ | ☐ | ☐ |
| As I get older I get wiser | ☐ | ☐ | ☐ | ☐ | ☐ |
| As I get older I continue to grow as a person | ☐ | ☐ | ☐ | ☐ | ☐ |
| As I get older I appreciate things more | ☐ | ☐ | ☐ | ☐ | ☐ |
| The quality of my social life in later years depends on me | ☐ | ☐ | ☐ | ☐ | ☐ |
| The quality of my relationships with others in later life depends on me | ☐ | ☐ | ☐ | ☐ | ☐ |
| Whether I continue living life to the full depends on me | ☐ | ☐ | ☐ | ☐ | ☐ |
| Getting older makes me less independent | ☐ | ☐ | ☐ | ☐ | ☐ |
| As I get older I can take part in fewer activities | ☐ | ☐ | ☐ | ☐ | ☐ |
| As I get older I do not cope well with problems that arise | ☐ | ☐ | ☐ | ☐ | ☐ |
| Slowing down with age is not something that I can control | ☐ | ☐ | ☐ | ☐ | ☐ |
| I have no control over the effects which getting older has on my social life | ☐ | ☐ | ☐ | ☐ | ☐ |
| I get depressed when I think about how ageing might affect the things that I can do | ☐ | ☐ | ☐ | ☐ | ☐ |
| I worry about the effects that getting older may have on my relationships with others | ☐ | ☐ | ☐ | ☐ | ☐ |
| I feel angry when I think about getting older | ☐ | ☐ | ☐ | ☐ | ☐ |
| As I get older I expect to become more lonely | ☐ | ☐ | ☐ | ☐ | ☐ |
| Old age is a time of loneliness | ☐ | ☐ | ☐ | ☐ | ☐ |

## THE NEXT SECTION ASKS YOU ABOUT YOUR EXPERIENCES OF THE COVID-19 PANDEMIC AND HOW THIS HAS AFFECTED YOUR LIFE.

### 74. IN THE LAST WEEK, HOW OFTEN DID YOU DO THE FOLLOWING ACTIVITIES, AS COMPARED TO BEFORE THE OUTBREAK - NOT AT ALL, LESS OFTEN, ABOUT THE SAME, OR MORE OFTEN?

| PLEASE TICK ONE BOX PER LINE | Not at all | Less often | About the same | More often |
|---|---|---|---|---|
| Leave your home | ☐ | ☐ | ☐ | ☐ |
| Go grocery shopping | ☐ | ☐ | ☐ | ☐ |
| Travel to visit family members | ☐ | ☐ | ☐ | ☐ |
| Travel to visit friends | ☐ | ☐ | ☐ | ☐ |
| Attend religious services outside your home | ☐ | ☐ | ☐ | ☐ |
| Exercise at home | ☐ | ☐ | ☐ | ☐ |
| Walk outside your home for more than 20 minutes | ☐ | ☐ | ☐ | ☐ |

### 75. PEOPLE HAVE BEEN ASKED TO SOCIALLY DISTANCE WHEN OUTSIDE (MEANING THAT THEY STAY AT LEAST TWO METRES APART FROM OTHERS.)

| PLEASE TICK ONE BOX | Always | Often | Sometimes | Never |
|---|---|---|---|---|
| Do you keep distance from others when you go outside your home? | ☐ | ☐ | ☐ | ☐ |

## 76. WE ARE STILL INTERESTED IN LEARNING ABOUT PEOPLE'S BEHAVIOURS DURING THE COVID-19 PANDEMIC. CAN YOU PLEASE TELL US IF YOU DO THE FOLLOWING:

| PLEASE TICK ONE BOX PER LINE | YES | NO |
|---|---|---|
| Wash your hands more frequently than usual? | ☐ | ☐ |
| Use special hand sanitizer or disinfection fluids? | ☐ | ☐ |
| Pay special attention to covering coughs and sneezes? | ☐ | ☐ |
| Take any drugs or medicine as a prevention against COVID-19? | ☐ | ☐ |
| Wear a protective face mask when outside the home, around other people? | ☐ | ☐ |

## 77. IN THE LAST MONTH, HOW OFTEN DID YOU HAVE CONTACT BY PHONE, EMAIL OR ANY OTHER ELECTRONIC MEANS WITH THE FOLLOWING PEOPLE FROM OUTSIDE YOUR HOME?

| PLEASE TICK ONE BOX PER LINE | Daily | Several times a week | About once a week | Less often | Never | |
|---|---|---|---|---|---|---|
| Children | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ No children |
| Parents | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ No parents |
| Other relatives | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ No other relatives |
| Neighbours / friends | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ No one else |

## 78. OVERALL, HOW SATISFIED ARE YOU WITH YOUR LIFE NOWADAYS?

| PLEASE CIRCLE ONE NUMBER | Not at all satisfied | | | | | | | | | Completely satisfied |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## 79. HERE IS A LIST OF STATEMENTS THAT PEOPLE HAVE USED TO DESCRIBE THEIR LIVES OR HOW THEY FEEL. PLEASE INDICATE HOW STRONGLY YOU AGREE OR DISAGREE WITH EACH OF THE FOLLOWING STATEMENTS.

| PLEASE TICK ONE BOX PER LINE | Strongly disagree | Disagree | Disagree slightly | Agree slightly | Agree | Strongly agree |
|---|---|---|---|---|---|---|
| I enjoy making plans for the future and working to make them a reality | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| My daily activities often seem trivial and unimportant to me | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| I am an active person in carrying out the plans I set for myself | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| I don't have a good sense of what it is I'm trying to accomplish in life | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| I sometimes feel as if I've done all there is to do in life | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| I live life one day at a time and don't really think about the future | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| I have a sense of direction and purpose in my life | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## 80. OVER THE LAST WEEK, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?

| PLEASE TICK ONE BOX PER LINE | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious or on edge | ☐ | ☐ | ☐ | ☐ |
| Not being able to stop or control worrying | ☐ | ☐ | ☐ | ☐ |
| Worrying too much about different things | ☐ | ☐ | ☐ | ☐ |
| Trouble relaxing | ☐ | ☐ | ☐ | ☐ |
| Being so restless that it is hard to sit still | ☐ | ☐ | ☐ | ☐ |
| Becoming easily annoyed or irritable | ☐ | ☐ | ☐ | ☐ |
| Feeling afraid as if something awful might happen | ☐ | ☐ | ☐ | ☐ |

## 81. SINCE THE OUTBREAK OF THE COVID-19 PANDEMIC IN MARCH 2020, WAS THERE ANY TIME WHEN YOU NEEDED MEDICAL (INCLUDING DENTAL) CARE, BUT DELAYED GETTING IT, OR DID NOT GET IT AT ALL?

**PLEASE TICK ONE BOX**

Yes ☐

No ☐ IF 'NO' GO TO QUESTION 84

## 82. WHY DID YOU DELAY OR NOT GET THAT CARE?

**PLEASE TICK ALL THAT APPLY**

I could not afford it ☐

I could not get an appointment ☐

The clinic / hospital / doctor's office cancelled ☐

I decided it could wait ☐

I was afraid to go ☐

## 83. WHAT TYPE(S) OF CARE OR HEALTH SERVICES DID YOU DELAY?

**PLEASE TICK ALL THAT APPLY**

| | | | |
|---|---|---|---|
| Major Surgery (requiring a hospital stay of one or more nights) | ☐ | Public health or Community Nurse | ☐ |
| Minor Surgery as an outpatient or day case | ☐ | Occupational therapy | ☐ |
| Seeing your General Practitioner | ☐ | Physiotherapy services | ☐ |
| Getting a prescription filled | ☐ | Psychological/counselling services | ☐ |
| Getting medications | ☐ | Hearing services | ☐ |
| Dental care | ☐ | Respite services | ☐ |
| Optician | ☐ | Other | ☐ |

## 84. DID YOU AVAIL OF A TELEPHONE OR ONLINE APPOINTMENT FROM ANY OF THE FOLLOWING?

**PLEASE TICK ALL THAT APPLY**

- General practitioner ☐
- Pharmacist ☐
- Hospital doctor ☐
- Any other health professional ☐
- Other, please specify: _____

## 85. SINCE THE OUTBREAK OF THE COVID-19 PANDEMIC IN MARCH 2020, HAVE YOU STARTED TAKING A VITAMIN D SUPPLEMENT AND IF SO, WHAT DOSAGE (PER DAY)?

**NOTE: THIS ALSO INCLUDES ANY MULTIVITAMIN OR SUPPLEMENT THAT INCLUDES VITAMIN D THAT YOU MAY HAVE STARTED TAKING SINCE THE START OF THE PANDEMIC**

**PLEASE TICK ONE BOX**

- Yes, 400IU (10ug) ☐
- Yes, 800IU (20ug) ☐
- Yes, 1000IU (25ug) ☐
- Yes, other dosage (please specify) ☐
- Specify: ☐
- Yes, but don't know dosage ☐
- No ☐
- I was already taking vitamin D before the COVID-19 pandemic ☐

## 86. DO YOU FIND THE OFFICIAL IRISH GOVERNMENT GUIDANCE ON COVID-19 EASY TO UNDERSTAND?

| PLEASE TICK ONE BOX | Extremely easy | Somewhat easy | Somewhat difficult | Extremely difficult |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ |

## 87. HOW WOULD YOU RATE YOUR KNOWLEDGE ABOUT COVID-19?

| PLEASE TICK ONE BOX | Extremely good | Somewhat good | Neither good nor bad | Somewhat bad | Extremely bad |
|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | ☐ |

## 88. OVERALL, ON A SCALE FROM 1 TO 10, HOW CONCERNED ARE YOU ABOUT THE COVID-19 PANDEMIC?

| PLEASE CIRCLE ONE NUMBER | Least concerned | | | | | | | | | Most concerned |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## 89. DO YOU THINK THAT YOU HAVE OR HAVE HAD COVID-19?

**PLEASE TICK ONE BOX**

- Yes, confirmed by a positive PCR test ☐
- Yes, confirmed by a positive Antigen OR Lateral Flow Test (LFT) test ☐
- Yes, confirmed by a positive Antigen AND Lateral Flow Test (LFT) test ☐
- Yes, suspected by a doctor but not tested ☐
- Yes, my own suspicions but not confirmed by a doctor or test ☐
- No, confirmed by a negative test ☐
- No, not to my knowledge ☐

IF 'YES' GO TO QUESTION 90

IF 'NO' GO TO QUESTION 104

## 90. IN WHICH MONTH AND YEAR DID YOU FIRST GET DIAGNOSED WITH OR FEEL THAT YOU HAD COVID-19?

Month: _____ Year: 2020 ☐ 2021 ☐ 2022 ☐

## 91. DID YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS AT THIS TIME?

**PLEASE TICK ALL THAT APPLY**

| | |
|---|---|
| Shortness of breath | ☐ |
| Cough | ☐ |
| Fever | ☐ |
| Sore throat | ☐ |
| Diarrhoea | ☐ |
| Loss of sense of smell or taste | ☐ |
| Nausea or vomiting | ☐ |
| Muscle or joint pain | ☐ |
| Fatigue | ☐ |
| Increased falls | ☐ |
| Confusion | ☐ |
| None of these | ☐ |

## 92. DID YOU GET COVID-19 DURING OR IMMEDIATELY AFTER A NON-COVID-19 RELATED STAY IN HOSPITAL?

**PLEASE TICK ONE BOX**

Yes ☐

No ☐

## 93. DID YOU MAKE A FULL RECOVERY FROM COVID-19? BY FULL RECOVERY, WE MEAN THAT ALL OF YOUR SYMPTOMS HAVE NOW RESOLVED AND YOU FEEL THAT YOU HAVE RETURNED TO YOUR HEALTH STATUS PRIOR TO HAVING COVID-19

**PLEASE TICK ONE BOX**

Yes ☐

No ☐

IF 'YES' GO TO QUESTION 94

IF 'NO' GO TO QUESTION 95

## 94. HOW MANY WEEKS WERE YOU SICK BEFORE YOU FELT THAT YOU MADE A FULL RECOVERY FROM COVID-19?

_____ WEEKS

GO TO QUESTION 96

## 95. HOW MANY WEEKS HAVE YOU NOW HAD SYMPTOMS OF COVID-19?

_____ WEEKS

## 96. DID YOU REQUIRE HOSPITAL TREATMENT FOR COVID-19?

**PLEASE TICK ONE BOX**

Yes ☐

No ☐

IF 'YES' GO TO QUESTION 97

IF 'NO' GO TO QUESTION 100

## 97. IN WHICH MONTH AND YEAR WAS THIS?

Month: _____ Year: 2020 ☐ 2021 ☐ 2022 ☐

## 98. HOW MANY NIGHTS DID YOU SPEND IN HOSPITAL?

_____ NIGHTS

## 99. WERE YOU ON OXYGEN TO HELP YOU BREATHE WHILE YOU WERE IN HOSPITAL?

**PLEASE TICK ONE BOX**

Yes ☐

No ☐

## 100. DO YOU THINK THAT YOU HAVE OR HAVE HAD COVID-19 FOR A SECOND TIME?

**PLEASE TICK ONE BOX**

Yes, confirmed by a positive PCR test ☐

Yes, confirmed by a positive Antigen OR Lateral Flow Test (LFT) test ☐

Yes, confirmed by a positive Antigen AND Lateral Flow Test (LFT) test ☐

Yes, suspected by a doctor but not tested ☐

Yes, my own suspicions but not confirmed by a doctor or test ☐

No, confirmed by a negative test ☐

No, not to my knowledge ☐

IF 'YES' GO TO QUESTION 101

IF 'NO' GO TO QUESTION 104

## 101. IN WHICH MONTH AND YEAR DID YOU GET DIAGNOSED WITH OR FEEL THAT YOU HAD COVID-19 FOR THE SECOND TIME?

Month: _____ Year: 2020 ☐ 2021 ☐ 2022 ☐

## 102.DO YOU THINK THAT YOU HAVE OR HAVE HAD COVID-19 FOR A THIRD TIME?

**PLEASE TICK ONE BOX**

- Yes, confirmed by a positive PCR test ☐
- Yes, confirmed by a positive Antigen OR Lateral Flow Test (LFT) test ☐
- Yes, confirmed by a positive Antigen AND Lateral Flow Test (LFT) test ☐
- Yes, suspected by a doctor but not tested ☐
- Yes, my own suspicions but not confirmed by a doctor or test ☐
- No, confirmed by a negative test ☐
- No, not to my knowledge ☐

IF 'YES' GO TO QUESTION 103

IF 'NO' GO TO QUESTION 104

## 103. IN WHICH MONTH AND YEAR DID YOU GET DIAGNOSED WITH OR FEEL THAT YOU HAD COVID-19 FOR THE THIRD TIME?

Month: _____ Year: 2020 ☐ 2021 ☐ 2022 ☐

## 104. EXCLUDING YOURSELF, HAS ANYONE IN YOUR HOUSEHOLD BEEN DIAGNOSED WITH COVID-19?

**PLEASE TICK ONE BOX**

Yes ☐

No ☐

IF 'YES' GO TO QUESTION 105

IF 'NO' GO TO QUESTION 107

## 105. WHAT IS THEIR RELATIONSHIP TO YOU?

**PLEASE TICK ALL THAT APPLY**

| | |
|---|---|
| Spouse / partner | ☐ |
| Son(s) or daughter(s) | ☐ |
| Parent(s) | ☐ |
| Grandchild(ren) | ☐ |
| Sibling(s) | ☐ |
| Carer | ☐ |
| Other, (please specify): | |

## 106. DID THE MEMBERS OF YOUR HOUSEHOLD WHO WERE DIAGNOSED WITH COVID-19 EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS AT THAT TIME?

**PLEASE TICK ALL THAT APPLY**

| | |
|---|---|
| Shortness of breath | ☐ |
| Cough | ☐ |
| Fever | ☐ |
| Sore throat | ☐ |
| Diarrhoea | ☐ |
| Loss of sense of smell or taste | ☐ |
| Nausea or vomiting | ☐ |
| Muscle or joint pain | ☐ |
| Fatigue | ☐ |
| Increased falls | ☐ |
| Confusion | ☐ |
| None of these | ☐ |

## 107. HAVE YOU BEEN IN CLOSE CONTACT WITH ANYONE WITH COVID-19?

**PLEASE TICK ALL THAT APPLY**

| | |
|---|---|
| Yes, I was in contact with a confirmed COVID-19 case | ☐ |
| Yes, I was in contact with a suspected COVID-19 case | ☐ |
| No, not to my knowledge | ☐ |

## 108. IF A COVID-19 VACCINE WAS RECOMMENDED EACH YEAR, LIKE THE FLU VACCINE, HOW LIKELY ARE YOU TO GET A COVID-19 VACCINE EVERY YEAR?

**PLEASE TICK ONE BOX**

- Very Unlikely ☐
- Somewhat unlikely ☐
- Somewhat likely ☐
- Very likely ☐
- Unsure ☐

IF 'VERY LIKELY' GO TO QUESTION 110
OTHERWISE, GO TO QUESTION 109

## 109. IF YOU ARE AT ALL HESITANT ABOUT A YEARLY COVID VACCINE, WHICH OF THE FOLLOWING, IF ANY, ARE REASONS FOR THIS HESITANCY?

**PLEASE TICK ALL THAT APPLY**

- I am concerned about the side effects and safety ☐
- I am concerned that the COVID-19 vaccine is being developed too fast ☐
- I think the COVID-19 vaccine will not work ☐
- I already had COVID-19 so I think I should be immune ☐
- I am worried the vaccine could give me COVID-19 ☐
- I think COVID-19 is not a serious illness ☐
- I don't like vaccines
- I don't like needles ☐
- Other, (please specify): ☐

## 110. IF YOU ARE OPEN TO RECEIVING A YEARLY COVID VACCINE, WHO WOULD YOU LIKE TO RECEIVE A YEARLY COVID VACCINE FROM?

**PLEASE TICK ONE BOX**

A GP ☐

A nurse in a GP surgery ☐

A pharmacist ☐

Occupational health (i.e. at work) ☐

I will not get the vaccine ☐

A vaccination centre (e.g. Aviva Stadium) ☐

Unsure ☐

Other, (please specify) ☐

Specify: _____

## 111. TRAGICALLY, MANY PEOPLE HAVE LOST LOVED ONES DUE TO COVID-19. HAS ANYONE CLOSE TO YOU, SUCH AS A FAMILY MEMBER OR FRIEND, DIED WITH COVID-19?

**PLEASE TICK ONE BOX**

Yes ☐

No ☐

## 112. IF, SADLY, SOMEONE YOU KNOW HAS DIED WITH COVID-19, WHAT WAS THEIR RELATIONSHIP TO YOU?

**PLEASE TICK ALL THAT APPLY**

| | | | | | |
|---|---|---|---|---|---|
| Spouse / partner | ☐ | Son(s) or daughter(s) | ☐ | Friend(s) / neighbour(s) | ☐ |
| Parent(s) | ☐ | Grandchild(ren) | ☐ | Carer | ☐ |
| Sibling(s) | ☐ | Other relative(s) | ☐ | Other, specify: _____ | |

## 113. PLEASE FILL IN THE DATE ON WHICH YOU COMPLETED YOUR BOOKLET (E.G. 1ST OF MARCH 2022 = 01/03/22).

| D | D | / | M | M | / | Y | Y |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

## 114. WHAT IS IT THAT YOU ARE MOST LOOKING FORWARD TO DOING ONCE THE COVID-19 PANDEMIC ENDS?

**115. IF THERE IS ANYTHING YOU WOULD LIKE TO TELL US, PLEASE WRITE IN THE SPACE BELOW. FEEL FREE TO ADD A PAGE IF THIS SPACE IS INSUFFICIENT. WE SHALL BE VERY INTERESTED TO READ WHAT YOU HAVE TO SAY.**

**If you are affected by any of the issues raised in this questionnaire or are looking for information on COVID-19 (coronavirus) please contact:**

**ALONE COVID-19 support line** (Monday to Friday, 8am - 8pm). Tel: 0818 222 024.

**Age Action Information Service** (Monday to Friday, 9.30am - 5pm).
Tel: (01) 475 6989.

**COVID Community Response** is a national support helpline for individuals and organisations seeking assistance from their local community. Tel: (021) 237 7809, Text: (086) 180 0256.

**Family Carers Ireland** will answer carers' specific queries. Tel: 1800 240 724.

**Health Service Executive (HSE) helpline** (Monday to Friday, 8am - 8pm, Saturday and Sunday, 9am - 5pm). Tel: 1850 241 850 or (041) 685 0300.

**The Irish Hospice Foundation** has a Bereavement Support Line that aims to provide connection, comfort and support in these exceptional times (Monday to Friday, 10am - 1pm). Freephone: 1800 807 077.

**THANK YOU VERY MUCH FOR TAKING THE TIME TO ANSWER OUR QUESTIONS. PLEASE POST THE QUESTIONNAIRE BACK IN THE PREPAID ENVELOPE PROVIDED. ALL OF YOUR ANSWERS WILL REMAIN CONFIDENTIAL.**