**SHIFT Study – Final follow-up Case Report Form**

Date of consent/completion:

(DD/MM/YYYY) / /

**Please fill out this questionnaire and return with your activity monitor in the SHIFT pack we have provided you with.**

**Thank you in advance for your continued participation in the SHIFT Study!**

**Anthropometric measurements**

If you have some electronic weighing scales at home, please insert your weight below. Please wear light clothing and stand on your scales with bare feet together.

**Weight . kg**

**Now, get a cup of tea and please fill out the rest of the questionnaire**

**Please read each question carefully and answer every question**

**Working hours and demographic information**

**1. Have you been furloughed during COVID-19? (please tick)**

Yes If Yes, please state the duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No

**2. Have you changed your shift pattern since your last health assessment?**

Yes If Yes, please tick your new shift pattern

Morning Afternoon Night

No If No, please go to the next question.

**3. Please state your average hours worked per week:**

*(this might differ from your contracted hours)*

**4. Has your marital status changed since your last health assessment?** (please tick)

Yes No If No, please go to the next page

**If yes**, please tick your most up to date marital status:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Single……………………………………………………… | |  | Separated…… |  |
| Co-habiting ………………………………………………. |  | Divorced…….. |  |
| Married (including those in civil partnerships – 1st marriage) …………………………………….…………. | |  | Widowed……. |  |
| Re-married ……………………………………………….. | |  | Other………… |  |

*Please state if Other Marital Status:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Has your level of education changed since your last health assessment?** (please tick):

Yes No If No, please go to the next page

**If yes,** please tick your most up to date level of education:

|  |  |  |  |
| --- | --- | --- | --- |
| GCSEs ….…..……………….. |  | Master’s degree………………………. |  |
| A-levels……………………….. |  | Professional or Doctorate degree (e.g. PhD)…………………………….. |  |
| University graduate (e.g. Bachelor’s degree)……..…… |  | Other ………………………………… |  |

*Please state if Other Level of Education:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diet**

**6. On an average week, please tick how often you eat at least ONE portion of the following foods & drinks**: (a portion includes: a handful of grapes, an orange, a serving of carrots, a side salad, a slice of bread, a glass of pop).

*(Please put ONE tick on EVERY line)*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Rarely or never** | **Less than 1 a Week** | **Once a Week** | **2-3 times a Week** | **4-6 times a Week** | **1-2 times a Day** | **3-4 times a Day** | **5+ a Day** |
| Fruit (tinned / fresh) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Fruit juice (not cordial or squash) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Salad (not garnish added to sandwiches) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Vegetables (tinned / frozen / fresh but not potatoes) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Chips / fried potatoes | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Beans or pulses like baked beans, chick peas, dahl | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Fibre-rich breakfast cereal, like Weetabix, Fruit ‘n Fibre, Porridge, Muesli | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Wholemeal bread or chapattis | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Cheese / yoghurt | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Crisps / savoury snacks | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Sweet biscuits, cakes, chocolate, sweets | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Ice cream / cream | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Non alcoholic fizzy drinks/pop  (not sugar free or diet) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Rarely or never** | **Less than 1 a Week** | **Once a Week** | **2-3 times a Week** | **4-6 times a Week** | **7+ times a week** |
| **Whole meats:** |  |  |  |  |  |  |
| Beef, Lamb, Pork, Ham - steaks, roasts, joints, mince or chops | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Chicken or Turkey – steaks, roasts, joints, mince or portions (not in batter or breadcrumbs) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| **Processed meats/ meat products** | |  |  |  |  |  |
| Sausages, bacon, corned beef, meat pies/pasties, burgers | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Chicken/turkey nuggets/twizzlers, turkey burgers, chicken pies, or in batter or breadcrumbs | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| **Fish:** |  |  |  |  |  |  |
| White fish in batter or breadcrumbs – like ‘fish ‘n chips’ | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| White fish not in batter or breadcrumbs | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Oily fish – like herrings, sardines, salmon, trout, mackerel, fresh tuna (not tinned tuna) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |

**Smoking and alcohol use**

**7. Has there been a change in your smoking status since your last health assessment?**

Yes No If No, please go to the next question

**If yes, please tick the corresponding box:**

I have stopped smoking in the last 6 months

I have started smoking in the last 6 months

If started smoking, please report how many cigarettes you smoke per day: \_\_\_\_\_\_\_\_\_\_\_\_

**8. Has there been a change in your alcohol intake since your last health assessment?**

Yes No If No, please go to the next question

**If yes**, please circle the answer most relevant to you in the questions below

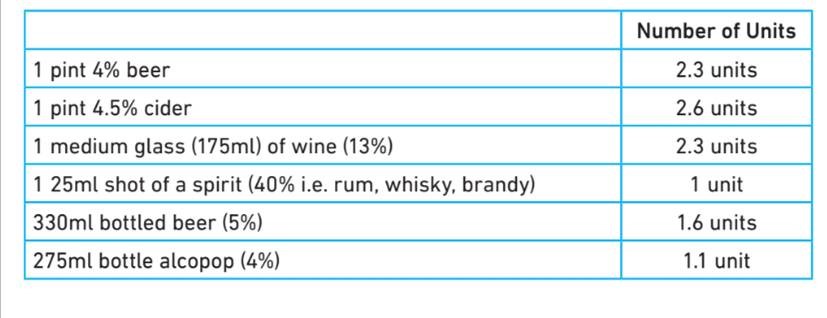
**8a. How often do you have a drink containing alcohol? (please circle)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Never | Monthly or | 2 to 4 | 2 to 3 | 4 or more times |
|  | less | times a month | times a week | a week |

**8b. How many units of alcohol do you have on a typical day when you are drinking? (please circle)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more |

Note: Please check the units chart below to work out the number of units contained in each drink.



**9. Musculoskeletal Problems:** The following questions refer to trouble experienced in muscles and joints which have progressively come about. **Please answer every question** even if you have never had trouble in any parts of your body. This picture shows how the body has been divided. You should decide for yourself which part (if any) is or has been affected.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Nordic Person |  | Have you at any time during the **past month** had trouble (such as ache, pain, discomfort, numbness) in**:** | | | | | | | | | | |
|  | 0  No trouble | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10  Severe trouble |
| **NECK** |  |  |  |  |  |  |  |  |  |  |  |
| **SHOULDER** |  |  |  |  |  |  |  |  |  |  |  |
| **UPPER BACK** |  |  |  |  |  |  |  |  |  |  |  |
| **ELBOW** |  |  |  |  |  |  |  |  |  |  |  |
| **WRIST/HAND** |  |  |  |  |  |  |  |  |  |  |  |
| **LOWER BACK** |  |  |  |  |  |  |  |  |  |  |  |
| **HIP/THIGH** |  |  |  |  |  |  |  |  |  |  |  |
| **KNEE** |  |  |  |  |  |  |  |  |  |  |  |
| **ANKLE/FEET** |  |  |  |  |  |  |  |  |  |  |  |

**10. Hospital Anxiety and Depression Scale (HADS)**

**Instructions -** Read every sentence. Place an X on the answer that best describes how you have been feeling during the **LAST WEEK**. For these questions, spontaneous answers are the most important.

|  |  |
| --- | --- |
| 1. I feel tense or wound up  Most of the time  A lot of the time  From time to time  Not at all  3. I get a sort of frightened feeling as if something awful is about to happen  Very definitely and quite badly  Yes, but not too badly  A little but it doesn’t worry me  Not at all  5. Worrying thoughts go through my mind  A great deal of the time  A lot of the time  From time to time but not often  Only occasionaly  7. I can sit at ease and feel relaxed  Definitely  Usually  Not often  Not at all  9. I get a sort of frightened feeling like  butterflies in the stomach  Not at all  Occasionally  Quite often  Very often | 2. I still enjoy the things I used to enjoy  Hardly at all  Only a little  Not quite as much  Definitely as much  4. I can laugh and see the funny side of things  Not at all  Definitely not so much now  Not quite as much now  As much as I always could    6. I feel cheerful  Not at all  Not often  Sometimes  Most of the time  8. I feel as if I am slowed down  Nearly all of the time  Very often  Sometimes  Not at all  10. I have lost interest in my appearance  Definitely  I don’t take as much care as I should  I may not take quite as much care  I take just as much care as ever |

|  |  |
| --- | --- |
| 11. I feel restless, as if I have to be on the  move  Very much indeed  Quite a lot  Not very much  Not at all  13. I get a sudden feeling of panic  Very often indeed  Quite often  Not very often  Not at all | 12. I look forward with enjoyment to things  As much as I ever did  Rather less than I used to  Definitely less than I used to  Hardly at all    14. I can enjoy a good TV or radio programme or book  Often  Sometimes  Not often  Very seldom |

**Social Isolation**

**11. Please respond to each item by marking with a “X” one box per row.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Never** | **Rarely** | **Sometimes** | **Usually** | **Always** |
| I feel left out……………………………. |  |  |  |  |  |
| I feel that people barely know me…… |  |  |  |  |  |
| I feel isolated from others ................... |  |  |  |  |  |
| I feel that people are around me but not with me ……………………………. |  |  |  |  |  |
| I feel isolated even when I am not alone……………………………………. |  |  |  |  |  |
| I feel that people avoid talking to me... |  |  |  |  |  |
| I feel detached from other people ....... |  |  |  |  |  |
| I feel like a stranger to those around me……………………………………….. |  |  |  |  |  |

**12. Utrecht Work Engagement Scale**

The following 9 statements are about how you feel at work. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, circle “0” (zero) in the space after the statement. If you have had this feeling, indicate how often you feel it by crossing the number (from 1 to 6) that best describes how frequently you feel that way.

0 = never 4 = often (once a week)

1 = almost never (a few times a year or less) 5 = very often (a few times a week)

2 = rarely (once a month or less) 6 = always (every day)

3 = sometimes (a few times a month)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| At my work, I feel bursting with energy | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| At my job, I feel strong and vigorous | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I am enthusiastic about my job | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| My job inspires me | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| When I get up in the morning, I feel like going to work | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I feel happy when I am working intensely | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I am proud of the work that I do | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I am immersed in my work | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I get carried away when I am working | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Occupational Fatigue Exhaustion Recovery (OFER 15) Scale**  **13. These statements are about your experience of FATIGUE and STRAIN at work and home OVER THE LAST 6 MONTHS. Please circle a number from 0-6.** | | | | | | | | |
|  | **Strongly**  **Disagree** | **Disagree** | **Slightly**  **Disagree** | **Neither**  **Agree or Disagree** | **Slightly**  **Agree** | **Agree** | **Strongly Agree** |
| 1) I often feel I’m ‘at the end of my rope’ with my work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 2) I often dread waking up to another day of my work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 3) I often wonder how long I can keep going at my work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 4) I feel that most of the time I’m just “living to work” | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 5) Too much is expected of me in my work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 6) After a work shift I have little energy left | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 7) I usually feel exhausted when I get home from work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 8) My work drains my energy completely every day | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 9) I usually have lots of energy to give to my family or friends | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 10) I usually have plenty of energy left for my hobbies and other activities after I finish work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 11) I never have enough time between shifts to recover my energy completely | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 12) Even if I’m tired from shift, I’m usually refreshed by the start of the next shift | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 13) I rarely recover my strength fully between shifts | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 14) Recovering from work fatigue between shifts isn’t a problem for me | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 15) I’m often still feeling fatigued from one shift by the time I start the next one | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

**Job Satisfaction**

14. Please **circle** the answer (from 1 to 7) where 1= dissatisfied and 7 = extremely satisfied.

**How satisfied are you with your job in general?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Job Performance**

14. Please **circle** the answer (from 1 to 7) where 1= very poorly and 7 = extremely well.

**How well do you think you have performed in your job recently?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Sickness Absence**

**15. Have you been absent from work due to sickness in the last 6 months?**

**Yes No**

If **yes,** how many *times* have you called in sick in the past 6 months? (please indicate how many times you have been sick according to the length of time you called in sick in the boxes below, for example, if you called in sick for 1 day on 5 separate occasions, insert ‘5’ next to ‘1 day of sick leave’ below)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Number of times |  |  | Number of times |
| 1 day of sick leave........................ |  |  | 11 to 15 consecutive days on sick leave………………………………. |  |
| 2 to 5 consecutive days on sick leave………………………………... |  |  | 16 to 20 consecutive days on sick leave……………………………….. |  |
| 6 to 10 consecutive days on sick leave………………………………… |  |  | More than 20 consecutive days sick leave………………………………… |  |

What is the *total*number of days of missed work because of sick leave in the past six months…….

**Presenteeism**

**16. In the past 6 months, have you come into work despite feeling unwell?**

**Yes No**

If **yes,** how many *times* have you come into work despite feeling unwell in the past 6 months? (please indicate how many times you have come into work despite feeling unwell according to the length of time of each occasion in the boxes below, for example, if you came into work despite feeling unwell on 1 day on 5 separate occasions, insert ‘5’ next to ‘1 day’ below)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Number of times |  |  | Number of times |
| 1 day…………………….……. |  |  | 11 to 15 consecutive days… |  |
| 2 to 5 consecutive days…….. |  |  | 16 to 20 days consecutive days |  |
| 6 to 10 consecutive days…… |  |  | More than 20 consecutive days |  |

What is the *total* number of days you have come into work despite not feeling well in the past six months….

**17. If you assume your current work ability at its best has a value of '10' points and at its worst '0'. How many points would you give your current workability?**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**18. Work Demands Questionnaire** *(Please tick the corresponding box)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never | Rarely | Some-times | Often | Always |
| Different groups at work demand things from me that are hard to combine……………………………………………... |  |  |  |  |  |
| I have unachievable deadlines…………………………….. |  |  |  |  |  |
| I have to work very intensively…………………………….. |  |  |  |  |  |
| I have to neglect some tasks because I have too much to do…………………………………………………………... |  |  |  |  |  |
| I am unable to take sufficient breaks……………………… |  |  |  |  |  |
| I am pressured to work long hours…...…………………… |  |  |  |  |  |
| I have to work very fast…………………………………….. |  |  |  |  |  |
| I have unrealistic time pressures……………………….…. |  |  |  |  |  |
| I can decide when to take a break………………………… |  |  |  |  |  |
| I have a say in my own work speed………………………. |  |  |  |  |  |
| I have a choice in deciding how I do my work…………… |  |  |  |  |  |
| I have a choice in deciding what I do at work……………. |  |  |  |  |  |
| I have some say over the way I work……………………... |  |  |  |  |  |
| My working time can be flexible…………………………… |  |  |  |  |  |
| I am given supportive feedback on the work I do………... |  |  |  |  |  |
| I can rely on my line manager to help me out with a work problem…………………………………………………….… |  |  |  |  |  |
| I can talk to my line manager about something that has upset or annoyed me about………………………………... |  |  |  |  |  |
| I am supported through emotionally demanding work….. |  |  |  |  |  |
| My line manager encourages me at work……….............. |  |  |  |  |  |
| If works get difficult, my colleagues will help me………… |  |  |  |  |  |
| I get help and support I need from colleagues….............. |  |  |  |  |  |
| I receive the respect at work I deserve from my colleagues……………………………………………………. |  |  |  |  |  |
| My colleagues are willing to listen to my work-related problems……………………………………………………... |  |  |  |  |  |

**Karolinska Sleepiness Scale**

|  |  |  |  |
| --- | --- | --- | --- |
| **19. How sleepy are you feeling right now? (please tick in the most appropriate)** | | | |
| Extremely alert……………………….. |  | Some signs of sleepiness………….. |  | |
| Very alert……………………………... |  | Sleep but no effort to keep awake… |  | |
| Alert…………………………………… |  | Sleepy some effort to keep awake... |  | |
| Rather alert…………………………… |  | Very sleepy great effort to keep awake, fighting sleep……………….. |  | |
| Neither alert nor sleepy……………... |  |  |  | |

# 20. Morningness-Eveningness Questionnaire

**Self-Assessment Version (MEQ-SA)**

For each question, please select the answer that best describes you by ticking the box that best indicates how you have felt in recent weeks.

1. **Approximately what time would you get up if you were entirely free to plan your day?**

|  |  |
| --- | --- |
| 5:00 AM – 6:30 AM (05:00–06:30 h)…… | 5 |
| 6:30 AM – 7:45 AM (06:30–07:45 h)…… | 4 |
| 7:45 AM – 9:45 AM (07:45–09:45 h)…… | 3 |
| 9:45 AM – 11:00 AM (09:45–11:00 h)….. | 2 |
| 11:00 AM – 12 noon (11:00–12:00 h)….. | 1 |

1. **During the first half hour after you wake up in the morning, how do you feel?**

|  |  |
| --- | --- |
| Very tired…………………………… | 1 |
| Fairly tired………………………….. | 2 |
| Fairly refreshed…………………….. | 3 |
| Very refreshed……………………... | 4 |

1. **At approximately what time in the evening do you feel tired, and as a result, in need of sleep?**

|  |  |
| --- | --- |
| 8:00 PM – 9:00 PM (20:00–21:00 h)…… | 5 |
| 9:00 PM – 10:15 PM (21:00–22:15 h)..... | 4 |
| 10:15 PM – 12:45 AM (22:15–00:45 h)… | 3 |
| 12:45 AM – 2:00 AM (00:45–02:00 h)….. | 2 |
| 2:00 AM – 3:00 AM (02:00–03:00 h)....... | 1 |

1. **At *approximately* what time of day do you usually feel your best?**

|  |  |
| --- | --- |
| 5:00 AM – 8:00 AM (05:00-08:00 h)*….…* | 5 |
| 8:00 AM – 10:00 AM (08:00-10:00 h).*….* | 4 |
| 10:00 AM – 5:00 PM (10:00-17:00 h).*.....* | 3 |
| 5:00 PM – 10:00 PM (17:00-22:00 h).*….* | 2 |
| 10:00 PM – 5:00 AM (22:00-05:00 h)….. | 1 |

1. **One hears about “morning types” and “evening types.” Which one of these types do you consider yourself to be?**

|  |  |
| --- | --- |
| Definitely a morning type………………………………….. | 4 |
| Rather more a morning type than an evening type…….. | 3 |
| Rather more an evening type than a morning type…….. | 2 |
| Definitely an evening type…………………………………. | 1 |

**21. Self-reported Driver Safety Behaviour**

To what extent do you agree or disagree with the following statements? *(please tick the relevant box on each line)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Strongly disagree | disagree | Neither disagree or agree | Agree | Strongly agree |
| I occasionally jump to get out of my lorry quickly |  |  |  |  |  |
| I always comply with the posted speed limits |  |  |  |  |  |
| I occasionally drive without getting enough sleep |  |  |  |  |  |
| I always use my log book legally |  |  |  |  |  |
| When I’m tired or rushed, I sometimes skip the daily vehicle inspection |  |  |  |  |  |
| I sometimes find myself in a difficult situation without having a way out |  |  |  |  |  |

|  |  |
| --- | --- |
| **22. Under each heading, please tick the ONE box that best describes your health TODAY.** | |
| MOBILITY |  |
| I have no problems in walking about……………………………………………….. | ❑ |
| I have slight problems in walking about……………………………………………. | ❑ |
| I have moderate problems in walking about………………………………………. | ❑ |
| I have severe problems in walking about………………………………………….. | ❑ |
| I am unable to walk about…………………………………………………………… | ❑ |
| SELF-CARE |  |
| I have no problems washing or dressing myself………………………………..… | ❑ |
| I have slight problems washing or dressing myself………………………………. | ❑ |
| I have moderate problems washing or dressing myself………………………….. | ❑ |
| I have severe problems washing or dressing myself…………………………….. | ❑ |
| I am unable to wash or dress myself………………………………………………. | ❑ |
| USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)* |  |
| I have no problems doing my usual activities……………………………………... | ❑ |
| I have slight problems doing my usual activities………………………………….. | ❑ |
| I have moderate problems doing my usual activities…………………………….. | ❑ |
| I have severe problems doing my usual activities………………………………… | ❑ |
| I am unable to do my usual activities………………………………………………. | ❑ |
| PAIN / DISCOMFORT |  |
| I have no pain or discomfort………………………………………………………… | ❑ |
| I have slight pain or discomfort……………………………………………………... | ❑ |
| I have moderate pain or discomfort………………………………………………… | ❑ |
| I have severe pain or discomfort……………………………………………………. | ❑ |
| I have extreme pain or discomfort………………………………………………….. | ❑ |
| ANXIETY / DEPRESSION |  |
| I am not anxious or depressed……………………………………………………… | ❑ |
| I am slightly anxious or depressed…………………………………………………. | ❑ |
| I am moderately anxious or depressed……………………………………………. | ❑ |
| I am severely anxious or depressed……………………………………………….. | ❑ |
| I am extremely anxious or depressed……………………………………………… | ❑ |

The best health you can imagine

10

0

20

30

40

50

60

80

70

90

100

5

15

25

35

45

55

75

65

85

95

|  |
| --- |
| 1. **We would like to know how good or bad your health is TODAY.** |
| This scale is numbered from 0 to 100. |
| 100 means the best health you can imagine. 0 means the worst health you can imagine. |
| Mark an X on the scale to indicate how your health is TODAY. |
| Now, please write the number you marked on the scale in the box below. |

YOUR HEALTH TODAY =

The worst health you can imagine

**24. Health-related Resource Use Questionnaire**

**In the last 6 months, what contact have you had with any of these health services?**

|  |  |  |
| --- | --- | --- |
|  | Have you had contact with? (please circle YES or NO) | If yes, please state number of contacts you have had in the last 6 months |
| General practitioner (GP) - Surgery visit | YES NO |  |
| General practitioner (GP) - Home visit | YES NO |  |
| General practitioner (GP) - Phone call | YES NO |  |
| General practice Nurse - Surgery visit | YES NO |  |
| General practice Nurse - Home visit | YES NO |  |
| General practice Nurse - Phone call | YES NO |  |
| Occupational Health Nurse | YES NO |  |
| Mental health nurse | YES NO |  |
| Physiotherapist | YES NO |  |
| Other counsellor/therapist (please state): | YES NO |  |
| Accident and Emergency Visit | YES NO |  |
| NHS Walk-in Centre Visit | YES NO |  |
| NHS Urgent Care Centre Visit | YES NO |  |
| Hospital Outpatient appointment | YES NO |  |

**In the last 6 months have you been admitted to hospital for overnight stays?**

YES / NO (please circle)

**If Yes**, please list details of each admission below if applicable:

|  |  |
| --- | --- |
| Reason for admission | Number of days |
|  |  |
|  |  |
|  |  |
|  |  |

**25. Has there been a change in any medications you have been taking since your last health assessment?**

Yes If Yes, please complete the table below.

No If No, please go to the next page.

**Please complete EVERY LINE on the form below regarding any current medications you are taking.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Type** | **Yes** | **No** | **Reason for medication** (e.g. high blood pressure) |
| ACE Inhibitor |  |  |  |
| Alpha-Blocker |  |  |  |
| ARB |  |  |  |
| Beta-Blocker |  |  |  |
| Calcium Channel Blocker |  |  |  |
| Diuretics/Thiazides |  |  |  |
| Aspirin |  |  |  |
| Lipid Lowering – Statin |  |  |  |
| Lipid Lowering – Fibrate |  |  |  |
| Steroids  Oral: □ Injected:□  Inhaled:□ |  |  |  |
| Anti-Thyroid Medication |  |  |  |
| Thyroxin Replacement |  |  |  |
| Multi-Vitamins |  |  |  |
| Vitamin C |  |  |  |
| Vitamin D |  |  |  |

**26. Have you engaged in any NEW form of physical activity since the COVID-19 outbreak (e.g., since 1st March)?**

Yes

No If No, please go to the next question

**If YES**, please give details:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**27. Participating in the SHIFT Study has given me the right knowledge to maintain a healthy lifestyle during the COVID-19 restrictions.**

Yes

No If No, please go to the next question

**If YES**, please give details:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**28. Since the COVID-19 restrictions, have you experienced any changes in your lifestyle and/or work which you feel may have a positive or negative impact on your overall health?**

Yes If Yes, please go to the next page

No If No, that is the end of the questionnaire

**If YES**, please give details:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have these changes been positive or negative, please select:

Positive

Negative

**Thank you for completing this questionnaire!**

**If you have any questions regarding the study, please contact the research team via the usual text messaging service**