SECTION 2: YOUR WELL-BEING

2.1 **In General, would you say your health is...**

	Poor	Fair	Good	Very Good	Excellent
Please TICK ONE box	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

2.2 This is a list of common long-term medical conditions. For each condition please tell me whether you have this condition or not. If you DO have it, please tell me how much it limits your daily activities from 1 (NOT AT ALL) to 5 (A LOT).

	Do you have this condition?		I DO have this condition and it limits my daily activities...				
	NO	YES	NOT AT ALL				A LOT
High blood pressure	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Heart problem e.g. heart disease, angina, heart failure, atrial fibrillation *(irregular heartbeat)*	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Chest or lung problem e.g. asthma, COPD, chronic bronchitis, emphysema	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Diabetes	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Chronic Kidney Disease	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Stroke or TIA *(mini stroke)*	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Cancer during the last 5 years *(not including small skin cancers)*	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Thyroid disorder	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Chronic back pain or sciatica	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Osteoarthritis *("regular" arthritis, not rheumatoid arthritis)*	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Rheumatoid arthritis or other rheumatology condition *(e.g. lupus)*	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Osteoporosis *(thinning of the bones)*	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	Do you have this condition?		I DO have this condition and it limits my daily activities... NOT AT ALL..........................A LOT				
	NO	YES					
Fibromyalgia, chronic fatigue syndrome or ME	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Stomach problems *(e.g. indigestion, ulcer)*	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Bowel problems *(e.g. IBS, diverticulitis, inflammatory bowel disease, constipation)*	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Overweight / Obesity	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Poor blood circulation in your legs including leg ulcers	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Skin condition	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Deafness or other severe problem with ears *(e.g. tinnitus)*	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Blindness or severe problem with vision	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Anxiety or Depression	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Severe mental health problems *(Schizophrenia, psychotic illness)*	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Dementia or severe memory problems	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Learning disability	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Neurological problem *(e.g. multiple sclerosis, Parkinson's, epilepsy)*	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Alcohol / drug problems	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Urinary problems *(e.g. incontinence, enlarged prostate)*	☐ 0	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Do you have any other long-term medical conditions that were not mentioned above? If so, please list them here:			**It limits my daily activities... NOT AT ALL..........................A LOT**				
			☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
			☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

SECTION 3: YOUR MOOD

3.1 **Please choose one response from the four given which comes closest to how you have been feeling in the past week.**

The HADS instrument was used with permission.