

WISCONSIN QUALITY OF LIFE CLIENT QUESTIONNAIRE

Wisconsin Quality of Life Associates
University of Wisconsin - Madison

Your Name: _____ ID #: _____

Date of Completion: ___/___/___ Location: _____

Directions: We are interested in your views and feelings. The questions in this booklet ask for your opinions about the quality of your life. When you answer each question please indicate the response which most closely reflects your opinion.

You are the person who knows best how you feel about these questions. If you would like someone to help you in filling out this questionnaire, and a friend or family member is not available, please contact a staff member to assist you.

Note: If this form was filled out by someone other than you, please...

Indicate who helped: _____

Relationship to you: _____

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BACKGROUND INFORMATION

What is your date of birth? ____/____/____

You are? Male Female

What is your highest school grade completed: _____

What is your current relationship/marital status?

- Single/Never married
- Married
- Divorced
- Committed relationship
- Separated
- Spouse deceased

How many times have you been married? _____

What is the source of your income? (Check all that apply)

- Paid employment
- Social Security Disability Income (SSDI) or Supplemental Security Income (SSI)
- Veterans disability or pension benefits
- General assistance
- AFDC
- Unemployment compensation
- Retirement, investment or savings
- Alimony or child support
- Money shared by your spouse/partner
- Money from your family
- Other source: _____

What is your racial/ethnic background? (Check all that apply)

- American Indian/Native American
- Asian
- African American
- Hispanic/Latino
- White
- Other, please specify: _____

During the past four weeks, you lived: (Check all that apply)

- alone
- with roommate/friend
- with children
- with parents
- with significant other/spouse
- with other, please specify: _____

Who would you like to live with? (Check all that apply)

- alone
- friend/roommate
- with children
- with parents
- with significant other/spouse
- with other, please specify: _____

During the past four weeks, you lived primarily: (Check one)

- in an apartment/home
- in a boarding home
- in an group home or halfway house
- homeless
- at school/college
- in an institution (i.e. hospital or nursing home)
- in jail/prison
- other, please specify: _____

Where would you like to live? (Choose one)

- in an apartment/home
- in a boarding home
- in an group home or halfway house
- homeless
- at school/college
- in an institution (i.e. hospital or nursing home)
- in jail/prison
- other, please specify: _____

SATISFACTION LEVEL

	Very dissatisfied	Moderately dissatisfied	A little dissatisfied	Neither satisfied or dissatisfied	A little satisfied	Moderately satisfied	Very satisfied
How satisfied or dissatisfied are you with the way you spend your time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied or dissatisfied are you when you are alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied or dissatisfied are you with your housing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied or dissatisfied are you with your neighborhood as a place to live in?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied or dissatisfied are you with the food you eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied or dissatisfied are you with the clothing you wear?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied or dissatisfied are you with the mental health services you use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied or dissatisfied are you with your access to transportation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied or dissatisfied are you with your sex life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied or dissatisfied are you with your personal safety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

We have asked how satisfied you are with different parts of your life. Now we would like to know how important each of these aspects of your life are.

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
How important to you is the way you spend your time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important is it to feel comfortable when alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important is your housing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important is your neighborhood as a place to live in?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important to you is the food you eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important to you is the clothing you wear?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important to you are the mental health services you use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important to you is your access to transportation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important to you is your sex life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important to you is your personal safety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ACTIVITIES AND OCCUPATIONS

During the **past four weeks**, you have: (Check one)

- been working/studying or doing housework in your usual manner
- been working/studying or doing housework but less often
- stopped working/studying or doing housework

About how many hours a week do you work or go to school? Hours per week = _____

What is your main activity? (Check one).

- Paid employment
- Volunteer or unpaid work
- School
- Treatment/rehabilitation program
- Craft/leisure time/hobbies
- No structured activity
- Other, please specify: _____

How satisfied or dissatisfied are you with the main activity that you do? (Check one)

- Very dissatisfied
- Moderately dissatisfied
- A Little dissatisfied
- Neither satisfied nor dissatisfied
- A little satisfied
- Moderately satisfied
- Very satisfied

Do you feel that you are engaged in activities: (Choose one)

- Less than you would like
- More than you would like
- As much as you want

What would you like to have as your main activity?

- Paid employment
- Volunteer or unpaid work
- School
- Treatment/rehabilitation program
- Craft/leisure time/hobbies
- No structured activity
- Other, please specify: _____

PSYCHOLOGICAL WELL-BEING

Now we would like to know how you feel about things in your life. For each of the following questions, check the boxes that best describe how you have felt in the **past four weeks**.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Pleased about having accomplished something?
<input type="checkbox"/>	<input type="checkbox"/>	Very lonely or remote from other people?
<input type="checkbox"/>	<input type="checkbox"/>	Bored?
<input type="checkbox"/>	<input type="checkbox"/>	That things went your way?
<input type="checkbox"/>	<input type="checkbox"/>	So restless that you couldn't sit long in a chair?
<input type="checkbox"/>	<input type="checkbox"/>	Proud because someone complimented you on something you had done?
<input type="checkbox"/>	<input type="checkbox"/>	Upset because someone criticized you?
<input type="checkbox"/>	<input type="checkbox"/>	Particularly excited or interested in something?
<input type="checkbox"/>	<input type="checkbox"/>	Depressed or very unhappy?
<input type="checkbox"/>	<input type="checkbox"/>	On top of the world?

In the **past four weeks**, would you say that your mental health has been:

- Poor
- Fair
- Good
- Very good
- Excellent

SYMPTOMS/OUTLOOK

During the **past four weeks**, you have: (Check one)

- generally felt calm and positive in outlook
 been having some periods of anxiety or depression
 generally been confused, frightened, anxious or depressed

There are many aspects of emotional distress including feelings of depression, anxiety, hearing voices, etc. In the **past four weeks**, how much distress have these symptoms caused you?: (Check one)

- Not at all A little Some A moderate amount A lot

In the past four weeks :	Never	Occasionally	Frequently	Most of the time	Constantly
How much has feelings of depression, anxiety, etc. interfered with your daily life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt like killing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt like harming others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHYSICAL HEALTH

In the **past four weeks**, you would best describe your physical health as:

- Poor Fair Good Very good Excellent

How do you feel about your physical health? (Check one)

- Very dissatisfied Moderately dissatisfied A little dissatisfied Neither satisfied nor dissatisfied A Little satisfied Moderately satisfied Very satisfied

How important to you is your physical health? (Check one)

- Not at all important Slightly important Moderately important Very important Extremely important

Are you currently taking psychiatric medications? Yes No (If no, go to next page)

If you are currently taking psychiatric medications, do you take them as prescribed? (Check one)

- Never Sometimes Always Very infrequently Quite often

If you are currently taking psychiatric medications, do you have side effects from them?

- None Slight Mild Moderate Severe

If you take medications for mental health problems, do you feel the medication helps control your symptoms?

- Not at all Some A fair amount Quite a bit Eliminates all symptoms

How do you feel about taking your psychiatric medications?

- Very dissatisfied Moderately dissatisfied A little dissatisfied Neither satisfied nor dissatisfied A little satisfied Moderately satisfied Very satisfied

ALCOHOL & OTHER DRUGS

Over the **past four weeks**, have you drank any alcohol? Yes No

If yes, on how many days have you had any alcohol to drink over the **past four weeks**? ____ (number of days)

What do you think about your alcohol use? (Check one)

- It is a big problem It is a minor problem Not a problem It helps a little It helps a lot

Over the **past four weeks**, have you used any street drugs (cocaine, marijuana, heroin, speed, LSD, etc.)?

- Yes No

If yes, on how many days have you had any alcohol to drink over the **past four weeks**? ____ (number of days)

What do you think about your drug use? (Check one)

- It is a big problem It is a minor problem Not a problem It helps a little It helps a lot

SOCIAL RELATIONS / SUPPORT

	Very dissatisfied	Moderately dissatisfied	A little dissatisfied	Neither satisfied or dissatisfied	A little satisfied	Moderately satisfied	Very satisfied
How satisfied or dissatisfied are you with the number of friends you have?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied or dissatisfied are you with how you get along with your friends? <input type="checkbox"/> No friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied or dissatisfied are you with your relationship with your family? <input type="checkbox"/> No family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you live with others, how satisfied or dissatisfied are you with the people with whom you live? <input type="checkbox"/> Live alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied or dissatisfied are you with how you get along with other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many people do you count as your friends?	<input type="checkbox"/> none	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-5	<input type="checkbox"/> over 5			

IMPORTANCE LEVEL

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
How important is it to have an adequate number of friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important is it to get along with your friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important are family relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you live with others, how important are the people with whom you live?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How important is it to get along with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the **past four weeks**, you have (check one):

- been having good relationships with others and receiving support from family and friends
 been receiving only moderate support from family and friends
 had infrequent support from family and friends or only when absolutely necessary

MONEY

Are you paid for working or attending school? Yes No

How do you feel about the amount of money you have?

- Very dissatisfied Moderately dissatisfied A little dissatisfied Neither satisfied nor dissatisfied A Little satisfied Moderately satisfied Very satisfied

How satisfied are you about the amount of control you have over your money?

- Very dissatisfied Moderately dissatisfied A little dissatisfied Neither satisfied nor dissatisfied A Little satisfied Moderately satisfied Very satisfied

How important to you is money?

- Not at all important Slightly important Moderately important Very important Extremely important

How important is it to you to have control over your money?

- Not at all important Slightly important Moderately important Very important Extremely important

How often does lack of money keep you from doing what you want to do?

- Never Sometimes Frequently Almost always

ACTIVITIES OF DAILY LIVING

Below are activities that you may have participated in recently. Please check YES or NO to indicate whether you have done the activity in the **past four weeks**.

	YES	NO		YES	NO
Gone to a restaurant or coffee shop	<input type="checkbox"/>	<input type="checkbox"/>	Gone shopping	<input type="checkbox"/>	<input type="checkbox"/>
Gone for a ride in a bus or car	<input type="checkbox"/>	<input type="checkbox"/>	Prepared a meal	<input type="checkbox"/>	<input type="checkbox"/>
Cleaned the room/apartment/home	<input type="checkbox"/>	<input type="checkbox"/>	Done the laundry	<input type="checkbox"/>	<input type="checkbox"/>

During the **past four weeks** you:

- have been able to do most things on your own (such as shopping, getting around town, etc.)
- have needed some help in getting things done
- have had trouble getting tasks done, even with help

In the **past four weeks**, how often have you had any problems with personal grooming (e.g. taking showers, brushing your teeth)?

- Never Sometimes Frequently Almost always

GOAL ATTAINMENT

What do you hope to accomplish *as a result of your mental health treatment*? Please write below up to 3 goals:

Goal 1: _____

How important is this goal?

Not at all important	1	2	3	4	5	6	7	8	9	10	Extremely important
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

To what extent has this goal been achieved?

Not at all achieved	1	2	3	4	5	6	7	8	9	10	Completely achieved
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Goal 2: _____

How important is this goal?

Not at all important	1	2	3	4	5	6	7	8	9	10	Extremely important
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

To what extent has this goal been achieved?

Not at all achieved	1	2	3	4	5	6	7	8	9	10	Completely achieved
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Goal 3: _____

How important is this goal?

Not at all important	1	2	3	4	5	6	7	8	9	10	Extremely important
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

To what extent has this goal been achieved?

Not at all achieved	1	2	3	4	5	6	7	8	9	10	Completely achieved
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

GOAL ATTAINMENT

Please write below your *agreed upon goals*:

Date: ____/____/____

Goal 1: _____

How important is this goal?

Not at all important	1	2	3	4	5	6	7	8	9	10	Extremely important
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

To what extent has this goal been achieved?

Not at all achieved	1	2	3	4	5	6	7	8	9	10	Completely achieved
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Goal 2: _____

How important is this goal?

Not at all important	1	2	3	4	5	6	7	8	9	10	Extremely important
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

To what extent has this goal been achieved?

Not at all achieved	1	2	3	4	5	6	7	8	9	10	Completely achieved
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

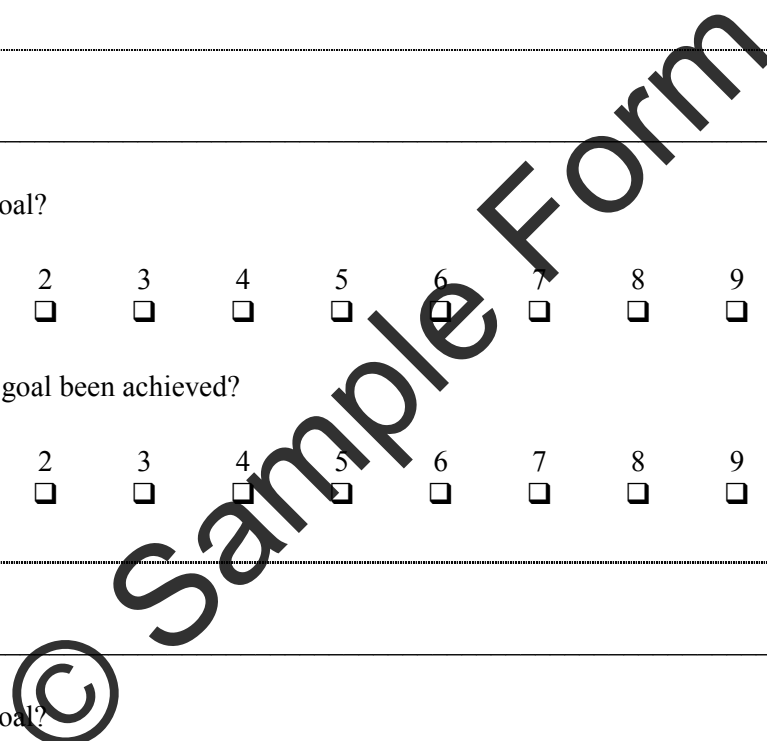
Goal 3: _____

How important is this goal?

Not at all important	1	2	3	4	5	6	7	8	9	10	Extremely important
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

To what extent has this goal been achieved?

Not at all achieved	1	2	3	4	5	6	7	8	9	10	Completely achieved
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



OTHER

Below are activities that you may have participated in recently. Please check Yes or No to indicate whether you have done the activity in the **past four weeks**.

	YES	NO		YES	NO
Gone for a walk	<input type="checkbox"/>	<input type="checkbox"/>	Gone to a social group	<input type="checkbox"/>	<input type="checkbox"/>
Gone to a movie or play	<input type="checkbox"/>	<input type="checkbox"/>	Read a magazine or newspaper	<input type="checkbox"/>	<input type="checkbox"/>
Watched TV	<input type="checkbox"/>	<input type="checkbox"/>	Gone to church, synagogue, mosque	<input type="checkbox"/>	<input type="checkbox"/>
Played cards	<input type="checkbox"/>	<input type="checkbox"/>	Listened to a radio	<input type="checkbox"/>	<input type="checkbox"/>
Played a sport	<input type="checkbox"/>	<input type="checkbox"/>	Gone to a library	<input type="checkbox"/>	<input type="checkbox"/>

Please check the box below to indicate how you feel about your quality of life during the **past four weeks**.

Lowest quality means things are as bad as they could be. *Highest quality* means things are the best they could be.

Lowest quality	1	2	3	4	5	6	7	8	9	10	Highest quality
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If your quality of life is less than you hope for, how hopeful are you that you will eventually achieve your desired quality of life? (Check one)

- Not at all Somewhat Moderately Very

How much control do you feel you have over the important areas of your life? (Check one)

- None Some A moderate amount A great amount

How important are each of the following factors in determining your quality of life?	Not at all important	Slightly important	Moderately important	Very important	Extremely important
Work, school or other occupational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your feelings about yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends, family, people you spend time with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having enough money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to take care of yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there anything else you would like us to know?

This is the end of the questionnaire. Thank you for giving your opinion and sharing your responses with us. If you have any questions about this questionnaire, please call or write Marion Becker, Ph.D., University of South Florida, Department of Community Mental Health, 13301 Bruce B. Downs Blvd., MHC 1423, Tampa, Florida 33612-3899 Telephone: (813) 974-7188 Fax: (813) 974-6469 E-Mail: becker@fmhi.usf.edu