Quality of Life Index
For Older Adults
Questionnaire

Your Name:_____

Today's Date: ____/____/____

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

Directions: We are interested in your views and feelings about your health status and the quality of your life. When you answer each question, please indicate the response that 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 the questionnaire please indicate who helped:

_____

Relationship to you:_____

Thank you for completing this questionnaire.

BACKGROUND INFORMATION

This questionnaire asks for your views about your health status and quality of life. Please begin by providing the following information about yourself. Please check (✓) the best answer.

You are? _____ Male _____ Female

What is your highest school grade completed: _____

What is your current marital status? Please check (✓) the most appropriate answer.

_____ Single/Never Married
_____ Married
_____ Divorced
_____ Separated
_____ Spouse deceased
_____ Living with partner (but not married)

What is your racial/ethnic background? Please check (✓) the most appropriate answer.

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

What is your religious affiliation? Please check (✓) the most appropriate answer.

_____ Catholic
_____ Jewish
_____ Protestant
_____ Muslim
_____ Other specify: _____
_____ None

Who do you currently live with? Please check (✓) the most appropriate answer.

_____ Living alone
_____ Living with spouse and/or children
_____ Living with non-relative
Other, please explain:_____

What is your current living arrangement? Please check (✓) the most appropriate answer.

_____ Living in own home
_____ Living in an apartment
_____ Living in a board and care facility
_____ Living in an institution
_____ Living in an assisted living facility
_____ Other, please explain: _____

What is your primary source of money? Please check (✓) all that apply.

_____ Savings, Interest Dividends	_____ Annuity
_____ Pensions	_____ Veterans' Benefits
_____ Family and Friends	_____ Disability Insurance
_____ Stocks and Bonds	_____ Job
_____ Social Security	Other, please specify: _____

PHYSICAL HEALTH

The following questions refer to your health status. Please check (✓) the most appropriate answer.

In general, would you say your physical health is:

_____ Poor _____ Fair _____ Good_____ Very Good _____ Excellent

Compared to one year ago, how would you rate your health in general **now**?

_____Much Worse	_____Somewhat Worse	_____ About the Same	_____Somewhat Better	_____ Much Better

Please choose the answer that best describes how true or false the following statements are for you.

Compared to others my age, my health is as good as can be expected.

_____Definitely False	_____Mostly False	_____Not Sure	_____Mostly True	_____Definitely True

I expect my health to get worse.

_____Definitely True	_____Mostly True	_____Not Sure	_____Mostly False	_____Definitely False

Do you take medication for your health? _____Yes _____No

If yes, how many different medications do you take? _____

(Include all medications; over the counter, prescribed, herbal, etc.)

	YES	NO
Do you require help in taking your medications correctly?	_____	_____
Are you bothered by side effects from your medications?	_____	_____

During the **past four weeks**, have your activities been limited in any of the following ways due to problems with your physical health?

	Yes, completely	**Yes, limited a lot**	**Yes, limited some**	**Yes, limited a little**	**No, not limited**
Limited the **kind** of activities you could do?	_____	_____	_____	_____	_____
Limited the **amount** of time you could do activities you would like to do?	_____	_____	_____	_____	_____
Limited you in **performing** self-care?	_____	_____	_____	_____	_____

The following questions are about activities you might do on a typical day. In the **past four weeks**, has your health limited you in any of the following activities?

	All Days	Most Days	Some Days	Few Days	No Days
Moderate Activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	_____	_____	_____	_____	_____
Lifting or carrying groceries.	_____	_____	_____	_____	_____
Climbing **several** flights of stairs.	_____	_____	_____	_____	_____
Climbing **one** flight of stairs.	_____	_____	_____	_____	_____
Bending, kneeling or stooping.	_____	_____	_____	_____	_____
Walking **several blocks**.	_____	_____	_____	_____	_____
Walking **one block**.	_____	_____	_____	_____	_____
Walking **short distances**. (e.g. around your house)	_____	_____	_____	_____	_____

SELF-CARE

These questions refer to self-care tasks. Please check (✓) the most appropriate answer.

During the **past four weeks...**

	All Days	Most Days	Some Days	Few Days	No Days
Did you need help from another person to take a bath or shower?	____	____	____	____	____
Did you need help from another person to get dressed?	____	____	____	____	____
Did you need help from another person to use the toilet?	____	____	____	____	____
Did you need help from another person to eat?	____	____	____	____	____
Did you need help from another person to get in or out of bed?	____	____	____	____	____

These questions refer to other important self-care tasks. Please check (✓) the most appropriate answer.

During the **past four weeks...**

	All Days	Most Days	Some Days	Few Days	No Days
Have you been able to go shopping for groceries without help?	____	____	____	____	____
Have you been able to prepare your own meals without help?	____	____	____	____	____
Have you been able to do your own housework without help?	____	____	____	____	____
Have you been able to do your own laundry without help?	____	____	____	____	____
Have you been able to use public transportation or drive your own car?	____	____	____	____	____

PAIN AND SYMPTOMS

How much pain have you had during the **past four weeks** (check one)?

_____Very Severe _____ Severe _____Moderate _____Mild _____Very Mild _____None

During the **past four weeks**, how much has pain interfered with your normal activities? (check one)

_____ Not at all _____Slightly _____Moderately _____Very much _____Completely interferes

Do you take pain medication? _____Yes _____No

If yes: Is your pain controlled by the medication you take?

_____Not at all _____Some _____Moderately _____Quite a bit _____Completely

Do you use other measures to control your pain? _____Yes _____No

If yes, what do you use? _____

_____

Overall, to what degree is your pain controlled?

_____Not at all _____Some _____Moderately _____Quite a bit _____Completely

Given the degree to which your pain is controlled, do you think something more should be done to help control your pain? _____Yes _____No

SOCIAL RELATIONS / SUPPORT

	Very dissatisfied	**Somewhat dissatisfied**	**Neither satisfied nor dissatisfied**	**Somewhat satisfied**	**Very satisfied**
How satisfied or dissatisfied are you with your relationships with family or friends?	_____	_____	_____	_____	_____
_____**No family or friends**					
How satisfied or dissatisfied are you with the amount of support you receive from family and friends?	_____	_____	_____	_____	_____

During the **past four weeks**, did you feel that your family or friends would be around if you needed assistance?

_____ Always _____ Often _____ Sometimes _____ Seldom _____ Never

During the **past four weeks,** how often did you go to a religious activity (e.g. church, synagogue, etc.) or attend a community activity? _____ (number of times)

During the **past four weeks,** did your physical health limit your ability to socialize with family or friends?

_____ Always _____ Often _____ Sometimes _____ Seldom _____ Never

During the **past four weeks,** did your emotional health limit your ability to socialize with family or friends?

_____ Always _____ Often _____ Sometimes _____ Seldom _____ Never

PSYCHOLOGICAL WELL-BEING

These questions are about how you have felt during the **past four weeks**. How much of the time. . .

	All Days	Most Days	Some Days	Few Days	No Days
Did you feel full of pep?	_____	_____	_____	_____	_____
Have you been nervous?	_____	_____	_____	_____	_____
Did you feel down in the dumps?	_____	_____	_____	_____	_____
Have you felt peaceful and content?	_____	_____	_____	_____	_____
Did you feel your life had purpose?	_____	_____	_____	_____	_____
Have you felt hopeful about the future?	_____	_____	_____	_____	_____
Have you worried about dying?	_____	_____	_____	_____	_____
Did you feel life was worthwhile?	_____	_____	_____	_____	_____
Did you feel in control of your life?	_____	_____	_____	_____	_____

During the **past four weeks,** have you experienced a major loss? _____ Yes _____ No

Please indicate below if during the **past four weeks** your activities have been limited in any of the following ways due to emotional difficulties.

	Yes, completely limited	**Yes, limited a lot**	**Yes, limited some**	**Yes, limited a little**	**No, not limited**
Limited the **kind** of activities you could do?	_____	_____	_____	_____	_____
Limited the **amount** of time you could do activities you would like to do?	_____	_____	_____	_____	_____
Limited you in **performing** self-care or attending social activities?	_____	_____	_____	_____	_____

Now we'd like to ask you about some other areas of your life. To what extent are you experiencing difficulty in the area of:

	All Days	**Most Days**	**Some Days**	**Few Days**	**No Days**
Managing day-to-day life (making decisions, handling money)?	_____	_____	_____	_____	_____
Getting enough sleep?	_____	_____	_____	_____	_____
Maintaining an adequate diet?	_____	_____	_____	_____	_____
Concentration, memory or confusion?	_____	_____	_____	_____	_____
Depression, hopelessness?	_____	_____	_____	_____	_____
Sexual activity?	_____	_____	_____	_____	_____
Mood swings?	_____	_____	_____	_____	_____
Drinking alcoholic beverages?	_____	_____	_____	_____	_____
Misusing drugs (including prescription drugs)?	_____	_____	_____	_____	_____

OTHER ISSUES

Please choose the answer that best describes how true or false the following statements are for you.

I spend time in activities that nourish my spiritual life.

_____Definitely False	_____Mostly False	_____Not Sure	_____Mostly True	_____Definitely True

I am not interested in activities that nourish my spiritual life.

_____Definitely False	_____Mostly False	_____Not Sure	_____Mostly True	_____Definitely True

I am satisfied with my spiritual life.

_____Definitely False	_____Mostly False	_____Not Sure	_____Mostly True	_____Definitely True

I feel that I am treated with dignity and respect.

_____Definitely False	_____Mostly False	_____Not Sure	_____Mostly True	_____Definitely True

	Very dissatisfied	**Somewhat dissatisfied**	**Neither satisfied or dissatisfied**	**Somewhat satisfied**	**Very satisfied**
How satisfied or dissatisfied are you with your living arrangements?	_____	_____	_____	_____	_____
How satisfied or dissatisfied are you with the amount of privacy that you have?	_____	_____	_____	_____	_____
How satisfied or dissatisfied are you with the choices you have (e.g. control over time and your daily activities)?	_____	_____	_____	_____	_____

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											**HIGHEST QUALITY**
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

You have answered questions about areas of your health and quality of life. These areas are listed below. **Please check (✓)** next to the **three most important areas** in which you would like to see improvement in your own life. Please read all areas before marking your selections.

Physical Health _____ Social Relations _____ Pain _____

Daily Activities _____ Social Support _____ Diet _____

Spirituality _____ Your Feelings _____ (mood/or mental health) Substance Use _____ (drugs/alcohol)

Self-Care _____

PERSONAL GOALS

Please list below the three most important personal goals that you have for improving your life.

Goal 1:_____

To what extent have you achieved this goal? Please check the box below to indicate the extent to which you have achieved this goal.

Not at all achieved											**Completely achieved**
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Goal 2:

_____

To what extent have you achieved this goal?

Not at all achieved											**Completely achieved**
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Goal 3: _____

To what extent have you achieved this goal?

Not at all achieved											**Completely achieved**
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	