

# Wisconsin Quality of Life Provider Questionnaire

Wisconsin Quality of Life Associates  
University of Wisconsin - Madison

Client Name: \_\_\_\_\_ Client ID #: \_\_\_\_\_

Date of Completion \_\_\_/\_\_\_/\_\_\_ Location: \_\_\_\_\_

Name of person filling out this form. \_\_\_\_\_  
(First Initial) (Last Name)



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**BACKGROUND INFORMATION**

What is your client's date of birth? \_\_\_\_/\_\_\_\_/\_\_\_\_

What is your client's sex?  Male  Female

**OCCUPATIONAL ACTIVITIES**

During the **past four weeks**, this person has: (Check one)

- been working/studying or doing housework in their usual manner
- been working/studying or doing housework but less often than they did before
- stopped working/studying or doing housework

What sort of work is this person generally capable of (even if unemployed, retired, or doing unpaid domestic duties)? (Check one)

- Capable of independent full-time work
- Capable of independent part-time work
- Capable of work only if given special support
- Totally incapable of work

**PSYCHOLOGICAL HEALTH**

In the past four weeks, would you say that this person's overall psychological health has been: (Check one)

- Poor
- Fair
- Good
- Very good
- Excellent

**PHYSICAL HEALTH**

During the **past four weeks**, this person has: (Check one)

- been feeling well or great most of the time
- been lacking energy or not feeling well more than just occasionally
- been feeling ill or poorly most of the time

Does this person have any significant medical illness or physical impairments other than mental illness?

- No
- Yes (Specify: \_\_\_\_\_)

How much of a physical problem do you think this person has from antipsychotic medication side effects?

- Severe
- Moderate
- Mild
- Slight
- None

**SOCIAL RELATIONS / SUPPORT**

During the **past four weeks**, this person has: (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

Does this person attend any social organization (e.g., church, club or interest group but excluding psychiatric therapy groups)? (Check one)

- Frequently
- Occasionally
- Rarely
- Never

Does this person generally make and keep up friendships? (Check one)

- Friendships made and kept up well
- Friendships made and kept up with some difficulty
- Friendships made and kept up with considerable difficulty
- Few friendships made and none kept up

How would you describe the quality of this person's relationship with his/her family? (Check one)

- None/has no relationships
- Poor
- Fair
- Good
- Very good
- Excellent

**ECONOMICS**

Is this person paid for working or attending school?  Yes  No

How does this person feel about the amount of money s/he has? (Check one)

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

How important to this person is money? (Check one)

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

How often does lack of money keep this person from doing what s/he wants to do? (Check one)

- Never   
  Sometimes   
  Frequently   
  Almost always

**ACTIVITIES OF DAILY LIVING**

During the **past four weeks** this person has: (Check one)

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

Does this person generally have any difficulty with initiating and/or responding to conversation?

- No difficulty   
  Slight difficulty   
  Moderate Difficulty   
  Extreme Difficulty

Is this person generally well groomed (e.g., neatly dressed, hair combed)?

- Well Groomed   
  Moderately well groomed   
  Poorly Groomed   
  Extremely poorly groomed

Does this person generally neglect his/her physical health?

- No neglect   
  Slight neglect   
  Moderate neglect   
  Extreme neglect

Does this person generally maintain an adequate diet?

- No problem   
  Slight problem   
  Moderate problem   
  Extreme problem

Does this person generally look after and take his/her own prescribed medication (or attend to prescribed injections on time) without reminding?  No Meds

- Reliable with medication   
  Slightly unreliable   
  Moderately unreliable   
  Extremely unreliable

Is this person generally inactive (e.g., spends most of the time sitting or standing around doing nothing)?

- Appropriately active   
  Slightly inactive   
  Moderately inactive   
  Extremely inactive

Does this person generally have definite interests (e.g., hobbies, sports, activities) in which s/he is involved regularly?

- Considerable involvement   
  Moderate involvement   
  Some involvement   
  Not involved at all

Can this person generally prepare (if needed) his/her own food or meals?

- Quite capable of preparing   
  Slight limitations   
  Moderate limitations   
  Totally incapable of preparing

Can this person generally budget (if needed) to live within his/her own means?

- Quite capable of budgeting   
  Slight limitations   
  Moderate limitations   
  Totally incapable of budgeting

Does this person have habits or behaviors that people find offensive?

- Not at all   
  Rarely   
  Occasionally   
  Often

**SYMPTOMS/OUTLOOK**

During the **past four weeks**, this person has:

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

Does this person behave dangerously because of confusion or preoccupation (e.g., ignoring traffic when crossing the road)?

- Not at all                     
 Rarely                                     
 Occasionally                                     
 Often

Please complete the following 24-item version of the Brief Psychiatric Rating Scale. The scale should be completed to reflect the person's current condition. Using the scale value below, enter the number in the box that best describes the person's present condition.

No problem 1	Very mild 2	Mild 3	Moderate 4	Moderately severe 5	Severe 6	Extremely severe 7
	Somatic Concern - preoccupation with physical health, fear of physical illness					Disorientation - confusion regarding person, place or time
	Anxiety - worry, fear, over concern for present or future					Conceptual Disorganization - thought process confused, disconnected, disorganized, disrupted
	Depressive mood - sorrow, sadness, despondency, pessimism					Excitement - heightened emotional tone, increased reactivity, impulsivity
	Guilt feelings - self-blame, shame, remorse for past behavior					Motor Retardation - slowed, weakened movements or speech, reduced body tone
	Hostility - animosity, contempt, belligerence, disdain for others					Blunted Affect - reduced emotional tone, reduction in normal intensity of feelings, flatness
	Suspiciousness - mistrust, belief others harbor malicious or discriminatory intent					Tension - physical and motor manifestations or nervousness, hyperactivity
	Unusual Thought Content - unusual, odd, strange, bizarre thought content					Mannerisms and Posturing - peculiar, bizarre, unnatural motor behavior
	Grandiosity - exaggerated self-opinion, arrogance, conviction of unusual power of abilities					Uncooperativeness - resistance, guardedness, rejection of authority
	Hallucinatory Behavior - perceptions without normal external stimulus correspondence					Bizarre Behavior - reports of odd, unusual, or psychotically criminal behavior
	Emotional Withdrawal - lack of spontaneous interaction, isolation, deficiency in relating to others					Elated Mood - euphoria, optimism that is out of proportion to circumstances
	Suicidality - expressed desire, intent, or actual actions to harm or kill self					Motor Hyperactivity - frequent movements and/or rapid speech
	Self-Neglect - hygiene, appearance, or eating below social standards					Distractibility - speech and actions interrupted by minor external stimuli or hallucinations/delusions

**GOAL ATTAINMENT**

What are *your goals for the mental health treatment* of this person? Please list up to 3 goals:

Goal 1: \_\_\_\_\_

How important is this goal?

<b>Not at all important</b>	1	2	3	4	5	6	7	8	9	10	<b>Extremely important</b>
	<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?

<b>Not at all achieved</b>	1	2	3	4	5	6	7	8	9	10	<b>Completely achieved</b>
	<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?

<b>Not at all important</b>	1	2	3	4	5	6	7	8	9	10	<b>Extremely important</b>
	<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?

<b>Not at all achieved</b>	1	2	3	4	5	6	7	8	9	10	<b>Completely achieved</b>
	<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?

<b>Not at all important</b>	1	2	3	4	5	6	7	8	9	10	<b>Extremely important</b>
	<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?

<b>Not at all achieved</b>	1	2	3	4	5	6	7	8	9	10	<b>Completely achieved</b>
	<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"/>	

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**GOAL ATTAINMENT**

Please write below your *agreed upon goals*:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Goal 1: \_\_\_\_\_

How important is this goal?

<b>Not at all important</b>	1	2	3	4	5	6	7	8	9	10	<b>Extremely important</b>
	<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?

<b>Not at all achieved</b>	1	2	3	4	5	6	7	8	9	10	<b>Completely achieved</b>
	<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?

<b>Not at all important</b>	1	2	3	4	5	6	7	8	9	10	<b>Extremely important</b>
	<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?

<b>Not at all achieved</b>	1	2	3	4	5	6	7	8	9	10	<b>Completely achieved</b>
	<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"/>	

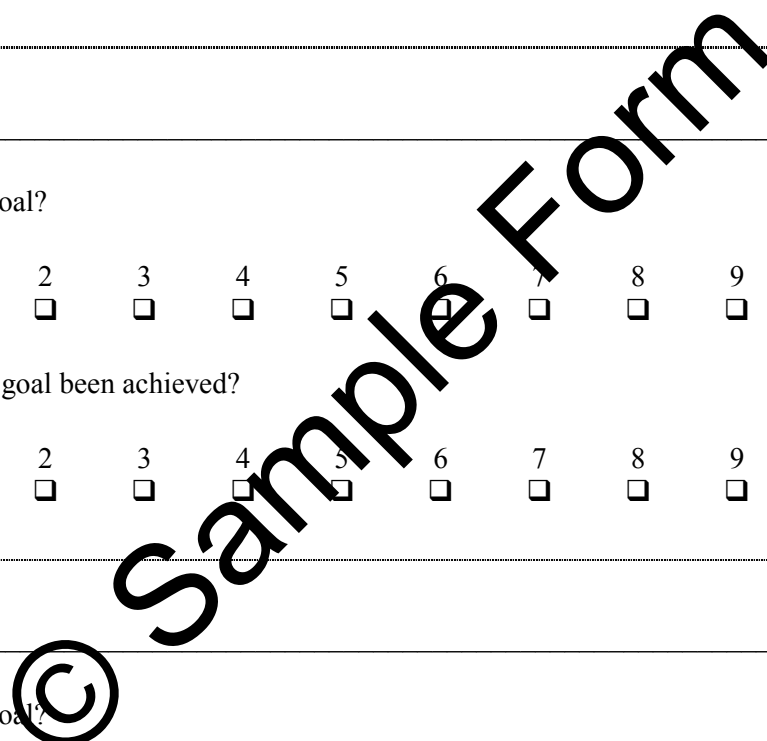
Goal 3: \_\_\_\_\_

How important is this goal?

<b>Not at all important</b>	1	2	3	4	5	6	7	8	9	10	<b>Extremely important</b>
	<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?

<b>Not at All Achieved</b>	1	2	3	4	5	6	7	8	9	10	<b>Completely Achieved</b>
	<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**

Please check a box below to indicate your rating of this person's 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.

<b>Lowest quality</b>	1	2	3	4	5	6	7	8	9	10	<b>Highest quality</b>
	<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"/>	

How confident are you that your rating of the person's quality of life is accurate? (Check one)

Not at all confident     Quite confident     Very confident     Absolutely confident

What is this person's primary psychiatric diagnosis? \_\_\_\_\_

How effective do you think the antipsychotic medication is in treating this person's mental illness?

Not at all effective     Slightly effective     Mildly effective     Moderately effective     Extremely effective

In the **past four weeks**, did this person take his/her antipsychotic medications as prescribed?

No medications prescribed (If you marked 'No Medications Prescribed', please skip the next question.)  
 None of the time     Very infrequently     Sometimes     Quite often     Always (if always, skip next question)

In the **past four weeks**, how much assistance did this person receive to take his/her prescribed medication?

Received considerable assistance     Received minor assistance/supervision     Received no assistance     Don't know

Does this person use alcohol or other drugs? (NOTE: If you mark 'Not at all', please skip the next question.)

Not at all     Rarely     Occasionally     Often

To what extent does this person's alcohol or other drug use concern you?

Not at all     Slightly     Moderately     A lot

Does this person get into trouble with the police?

Not at all     Rarely     Occasionally     Often     Don't know

Which of the following factors do you think are most important in maintaining your client's quality of life?	Not 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"/>
Feelings about him/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
His/her physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends, family, people s/he spends 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 him/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 we should know about this client?

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