

SCREENING QUESTIONNAIRE
Registration Information
This page is to be kept at Study Centre

Complete using CSHA-3 Subject Information Sheet:

Name: _____
Surname (Maiden Name) Given Names

CSHA-3 Address: _____
No. Street (Apt #)

Town/City Province Postal Code

CSHA-2 Residence: 1 Community 2 Institution
CSHA-3 Residence: 1 Community 2 Institution
Sex: 1 Male 2 Female **D.O.B.:** ____ / ____ / ____
DD MM YYYY

Complete during interview:

Primary Caregiver

Name: _____
Surname (Maiden Name) Given Names

CSHA-3 Address: _____
No. Street (Apt #)

Town/City Province Postal Code

Phone: _____
(Area code) Number

Second Caregiver

Name: _____
Surname (Maiden Name) Given Names

CSHA-3 Address: _____
No. Street (Apt #)

Town/City Province Postal Code

Phone: _____
(Area code) Number


Interviewer's name: _____ **Interviewer ID:** _____

English 5

CANADIAN STUDY OF HEALTH AND AGING-3

SCREENING QUESTIONNAIRE

Health Consent signed? Yes No
Protocol Assignment:
To Neuro 1
To Clinical 2
To Caregiver 3
Finished 4

 Time interview started: ____ : ____
(24-hour clock)

Date of interview: ____ / ____ / ____
 dd mm yyyy

Editor # _____

Interviewer # _____

As you know, I'm going to spend some time talking with you about your health and general circumstances. I will begin by asking you some questions about you and your family. As we said before - all of this information is confidential. Do you have any questions?

1. **How is your eyesight (with glasses or contacts if you wear them)? Is it excellent, good, fair, poor, or are you completely unable to see?** (Cue Card #1)

1 Excellent 2 Good 3 Fair 4 Poor 5 Unable to see 7 R 8 DK

2. **How is your hearing (with a hearing aid if you wear one)? Is it excellent, good, fair, poor, or are you completely unable to hear?** (Cue Card #2)

1 Excellent 2 Good 3 Fair 4 Poor 5 Unable to hear 7 R 8 DK

3. **What is your marital status?**

0 Never married 3 Divorced 7 R
1 Married 4 Separated 8 DK
2 Common law marriage 5 Widowed

If subject is in an institution, SKIP this question and go to Q.5. 6 Subject in institution

4. **Do you live here alone?** 1 Yes 2 No 7 R 8 DK

IF NO: **How many other people live here?** _____
(For each, say:) **How are they related to you?** (Include up to 6 people; identify by initials)

Relationship

Relationship

1. _____

4. _____

2. _____

5. _____

3. _____

6. _____

5. **People often have one or more individuals they can count on for help in time of need. Can you think of someone like this in your life?**

1 Yes 2 No 7 R 8 DK

IF YES: **How many such people?** Number: _____

- 5a. **Thinking now of the main such person, what is this person's relation to you?**
(Interviewer: Record name and address on registration sheet.)

1 Spouse 4 Friend 77 R
2 Child 5 Neighbour 88 DK
3 Sibling 6 Formal service provider, specify _____
7 Other, specify _____

D. Can you walk ...

2 <input type="checkbox"/> without any help?	1 <input type="checkbox"/> with some help? (From a person, or using a walker, crutches or chair)	0 <input type="checkbox"/> or are you completely unable to walk?	7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK
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E. Can you get in and out of bed ...

2 <input type="checkbox"/> without any help?	1 <input type="checkbox"/> with some help? (From a person or device)	0 <input type="checkbox"/> or are you completely unable to get in and out of bed unless someone lifts you?	7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK
--	--	--	--

F. Can you take a bath or shower ...

2 <input type="checkbox"/> without help?	1 <input type="checkbox"/> with some help? (From a person or device)	0 <input type="checkbox"/> or are you completely unable to bathe yourself?	7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK
--	--	--	--

G. Can you go to the bathroom or use a commode ...

2 <input type="checkbox"/> without help?	1 <input type="checkbox"/> with some help?	0 <input type="checkbox"/> or are you completely unable to use the bathroom or commode unless someone helps you?	7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK
--	--	--	--

H. Can you use the telephone ...

2 <input type="checkbox"/> without help? (Including looking up numbers and dialing)	1 <input type="checkbox"/> with some help? (Can answer phone, dial operator in an emergency, but need special phone or help in getting numbers or dialing)	0 <input type="checkbox"/> or are you completely unable to use the phone?	7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK
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I. Can you get to places out of walking distance ...

2 <input type="checkbox"/> without help? (Can travel alone on buses, taxis or drive your own car)	1 <input type="checkbox"/> with some help? (Need someone to help you or go with you when traveling)	0 <input type="checkbox"/> or are you completely unable to travel unless special arrangements are made?	7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK
--	--	--	--

J. Can you go shopping for your groceries or clothes ...

2 <input type="checkbox"/> without help? (Can take care of all shopping yourself)	1 <input type="checkbox"/> with some help? (Need someone to go with you on all shopping trips)	0 <input type="checkbox"/> or are you completely unable to shop?	7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK
--	---	--	--

K. Can you prepare your own meals ...

2 <input type="checkbox"/> without help? (Can plan and cook full meals?)	1 <input type="checkbox"/> with some help? (Can do some things but not prepare full meals)	0 <input type="checkbox"/> or are you completely unable to prepare your own meals?	7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK
---	---	--	--

L. Can you do your housework ...

2 <input type="checkbox"/> without help? (Can scrub floors etc.)	1 <input type="checkbox"/> with some help? (Can do light work but not heavy work)	0 <input type="checkbox"/> or are you completely unable to do housework?	7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK
---	--	--	--

M. Can you take your own medicine ...

2 <input type="checkbox"/> without help? (In the right doses, at the right time)	1 <input type="checkbox"/> with some help? (Can take medication if someone prepares it for you and reminds you to take it)	0 <input type="checkbox"/> or are you completely unable to take your own medicine?	7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK
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N. Can you handle your own money ...

2 <input type="checkbox"/> without help?	1 <input type="checkbox"/> with some help? (Can manage day-to-day buying but need help with your cheque book and paying bills)	0 <input type="checkbox"/> or are you completely unable to handle money?	7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK
--	---	--	--

O. During the past year, have you fallen hard enough to feel the pain afterwards?

1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	7 <input type="checkbox"/> R	8 <input type="checkbox"/> DK
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IF YES: **How many times?** Specify _____

P. How much of the time does bad health, sickness, or pain stand in the way of your doing things you would like to be doing? (Cue Card #5)

1 <input type="checkbox"/> Most of the time	4 <input type="checkbox"/> Seldom
2 <input type="checkbox"/> Frequently	5 <input type="checkbox"/> Never
3 <input type="checkbox"/> Sometimes	7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK

Is Subject in an institution? Yes No

SKIP Q - U IF SUBJECT IS IN AN INSTITUTION

Q. Do you take out the garbage yourself ...

Yes No R DK

IF YES: **Do you have great difficulty doing this yourself ...**

Yes No R DK

IF NO: **Could you do it yourself if necessary...**

Yes No R DK

R. Are you healthy enough to walk up and down stairs without help? (one flight of stairs)

Yes No R DK

S. Do you use a walker or 4-pronged cane at least some of the time to get around?

Yes No R DK

T. Do you use a wheelchair at least some of the time to get around?

Yes No R DK

U. In the last month, how many days a week have you usually gone out of the house or building in which you live?

Two or more days a week One day a week or less Never
 R DK

5. TODAY'S DATE

15

Today's date _____

Accurate 3

Missed by 1 or 2 days 2

Missed by 3-5 days 1

Missed by more than 5 days 0

Year _____

Accurate 8

Missed by 1 year 4

Missed by 2-5 years 2

Missed by more than 5 years 0

Season _____

Accurate or within a month 1

Missed 0

Month _____

Accurate or within 5 days 2

Missed by 1 month 1

Missed by more than a month 0

Day of week _____

Accurate 1

Missed 0

6. SPATIAL ORIENTATION

5

Province 2 0

City or town 1 0

*MMSE: **Number** Y N

(Place)

Country 1 0

Hosp., store, home 1 0

Street Y N

(Floor)

7. NAMING

5

Forehead 1 0

Chin 1 0

Shoulder 1 0


*MMSE: **Pencil** Y N

Not completed: Subject blind 66

Elbow 1 0

Knuckle 1 0

Watch Y N

8. FOUR-LEGGED ANIMALS (Write animals named)  (Timed item) (30 seconds)

10

_____ , _____ , _____ , _____ ,

_____ , _____ , _____ , _____ ,

_____ , _____ , _____ , _____ ,

_____ , _____ , _____ , _____ .

9. ___ SIMILARITIES (Write answer)


6

Arm-legLimbs, extremities 2 Body parts, bend, move, joint 1 Very weak similarity or no similarity 0 **Laughing-crying**Feeling, emotion 2 Expressions, sounds, relieve tension 1 Very weak similarity or no similarity 0 **Eating-sleeping**Necessary bodily functions 2 Bodily functions, relaxing, good for you 1 Very weak similarity or no similarity 0 **10. ___ REPETITION**

5

I would like to go home (out)Correct 2 1 or 2 missed/wrong words 1 More than 2 missed/wrong words 0 **No ifs** 1 0 **ands** 1 0 **or buts** 1 0 **11. ___ READ AND OBEY "CLOSE YOUR EYES" (Cue Card #6)**

3

Obeys without prompting 3 Obeys after prompting 2 Read aloud only 1 None of the above 0 Not completed: subject blind 66 subject illiterate 67 **12. ___ WRITING  (Timed item) (1 minute)**

5

(I) would like to go home (out) 0 1 2 3 4 5 *MMSE: Sentence Y NNot completed: subject physically unable 66 subject illiterate 67

Note handedness L 2 R 1

13. ___ COPYING TWO PENTAGONS

(Timed item) (1 minute)

10

	Pentagon 1	Pentagon 2
5 approx equal sides	4 <input type="checkbox"/>	4 <input type="checkbox"/>
5 unequal (2:1) sides	3 <input type="checkbox"/>	3 <input type="checkbox"/>
Other enclosed figures	2 <input type="checkbox"/>	2 <input type="checkbox"/>
2 or more lines	1 <input type="checkbox"/>	1 <input type="checkbox"/>
Less than 2 lines	0 <input type="checkbox"/>	0 <input type="checkbox"/>
	Intersection	
4 corners	2 <input type="checkbox"/>	
Not 4 corner enclosure	1 <input type="checkbox"/>	
No intersection or no enclosure	0 <input type="checkbox"/>	
Not completed: Physically unable	66 <input type="checkbox"/>	

14. ___ THREE STAGE COMMAND

3

Take this paper with your ...

Left/right hand	1 <input type="checkbox"/>	0 <input type="checkbox"/>	
fold it in half	1 <input type="checkbox"/>	0 <input type="checkbox"/>	
and hand it back to me	1 <input type="checkbox"/>	0 <input type="checkbox"/>	66 <input type="checkbox"/> Physically unable

15. ___ SECOND RECALL

9

Spontaneous recall: Shoes	3 <input type="checkbox"/>
Cue: Something to wear	2 <input type="checkbox"/>
Multiple: Shirt, shoes, socks	1 <input type="checkbox"/>
Missed completely	0 <input type="checkbox"/>
Spontaneous recall: Blue	3 <input type="checkbox"/>
Cue: A colour	2 <input type="checkbox"/>
Multiple: Black, brown, blue	1 <input type="checkbox"/>
Missed completely	0 <input type="checkbox"/>
Spontaneous recall: Modesty	3 <input type="checkbox"/>
Cue: A good personal quality	2 <input type="checkbox"/>
Multiple: Modesty, charity, honesty	1 <input type="checkbox"/>
Missed completely	0 <input type="checkbox"/>

_____ **3MS TOTAL SCORE**Time 3MS Completed: _____ : _____
(24-hour clock)

17. **During THE PAST 30 DAYS for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?**

_____ days

77 R

88 DK

18. **Here are some health problems that people often have. For each problem that I read, please tell me if you have had it in the PAST YEAR. You can just answer Yes or No. (If the problem began long ago and symptoms lasted into the past year, check “yes”. Do not read examples in parentheses unless the respondent asks for clarification.)**

	Yes	No	R	DK
A. High blood pressure (whether controlled by medication or not)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
B. Heart or circulation problems (hardening of the arteries, heart troubles or other blood diseases)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
C. Stroke or effects of stroke	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
D. Arthritis or rheumatism	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
E. Parkinson’s disease or other neurological problems (but do not include stroke)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
F. Eye trouble not relieved by glasses (cataracts, glaucoma)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
G. Ear trouble (hearing loss)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
H. Chest problems (asthma, pneumonia, T.B., emphysema, bronchitis, breathing problems)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
I. Troubles with your stomach or digestive system	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>

	Yes	No	R	DK
J. Back problems (excluding arthritis)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
K. Bladder control problems (by that I mean, did you pass water when you didn't intend to?)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
L. Problems controlling bowels (by that I mean, did you lose stool when you didn't intend to?)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
M. Any fractures <input type="checkbox"/> IF YES: Specify _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
N. Cancer <input type="checkbox"/> IF YES: Specify _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
O. Other <input type="checkbox"/> IF YES: Specify _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
P. In the PAST 5 YEARS, have you ever taken medication to control high blood pressure (hypertension)?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
Q. Has a doctor EVER told you that you have diabetes? <input type="checkbox"/> IF YES: Ask i, ii, and iii below:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
i. When was it diagnosed?	Year _____		7 <input type="checkbox"/>	8 <input type="checkbox"/>
ii. Which of the following measures do you currently use to control your diabetes? (check all that apply)	1 <input type="checkbox"/> None 2 <input type="checkbox"/> Diet 3 <input type="checkbox"/> Oral medication 4 <input type="checkbox"/> Insulin 7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK			
iii. How often is your blood sugar checked?	1 <input type="checkbox"/> Never 2 <input type="checkbox"/> Less than once a week 3 <input type="checkbox"/> Weekly 4 <input type="checkbox"/> More than weekly but less than daily 5 <input type="checkbox"/> Daily 7 <input type="checkbox"/> R 8 <input type="checkbox"/> DK			

Note to Interviewer:

If subject scored < 12 on 3MS Question 5, or < 2 on 3MS Question 15, OR is in an institution,
go to Q 25, page 19 **SKIP** 1

19. **Now, I would like to ask you about how you have been feeling. I will read you a list of ways you might have felt or behaved. As I read you each statement, please tell me how often you felt this way during THE PAST WEEK: Rarely, Some of the time, a Moderate amount of time, or Most of the time.** (Cue Card #9)

0 Rarely or none of the time (for less than 1 day in past week)

1 Some or a little of the time (1-2 days)

2 Occasionally or a moderate amount of the time (3-4 days)

3 Most or all of the time (5-7 days)

		Rarely	Some	Occas.	Most	R	DK
A.	I was bothered by things that don't usually bother me.	0	1	2	3	7	8
B.	I had trouble keeping my mind on what I was doing.	0	1	2	3	7	8
C.	I felt depressed.	0	1	2	3	7	8
D.	I felt that everything I did was an effort.	0	1	2	3	7	8
E.	I felt hopeful about the future.	0	1	2	3	7	8
F.	I felt fearful.	0	1	2	3	7	8
G.	My sleep was restless.	0	1	2	3	7	8
H.	I was happy.	0	1	2	3	7	8
I.	I felt lonely.	0	1	2	3	7	8
J.	I could not get going.	0	1	2	3	7	8

20. Now I would like to ask about your activities and interests. These might include visiting with friends or relatives, helping your family or others, physical activities like walking or swimming, and hobbies or crafts. DURING THE PAST YEAR, did you do any...

For each named activity, How often did you do this? (Cue Card # 9.5)

- | | |
|----------------------------|------|
| 1 Less than once a month | 7 R |
| 2 1-3 times a month | 8 DK |
| 3 Once a week | |
| 4 Two times or more a week | |

A. **Hobbies or crafts such as woodworking, knitting, sewing?**

Name of activity	Frequency						# of months	R	DK
	1	2	3	4	7	8			
	1	2	3	4	7	8		77	88
	1	2	3	4	7	8		77	88
	1	2	3	4	7	8		77	88
	1	2	3	4	7	8		77	88

B. **Physical activities or exercise such as walking, swimming, sports or working in the yard?**

Name of activity	Frequency						# of months	R	DK
	1	2	3	4	7	8			
	1	2	3	4	7	8		77	88
	1	2	3	4	7	8		77	88
	1	2	3	4	7	8		77	88
	1	2	3	4	7	8		77	88

C. **Group activities such as going to clubs, church or community centres, playing cards?**

Name of activity	Frequency						# of months	R	DK
	1	2	3	4	7	8			
	1	2	3	4	7	8		77	88
	1	2	3	4	7	8		77	88
	1	2	3	4	7	8		77	88
	1	2	3	4	7	8		77	88

D. **Helping family, friends, or volunteering?**

Name of activity	Frequency						# of months	R	DK
	1	2	3	4	7	8			
	1	2	3	4	7	8		77	88
	1	2	3	4	7	8		77	88
	1	2	3	4	7	8		77	88
	1	2	3	4	7	8		77	88

**21. We are interested in how things are going these days. Please answer “Yes” or “No”.
During THE PAST MONTH have you ever felt...**

A. In high spirits?

1 Yes 2 No 7 R 8 DK

B. Particularly content with your life?

1 Yes 2 No 7 R 8 DK

C. Depressed or very unhappy?

1 Yes 2 No 7 R 8 DK

D. Flustered because you didn’t know what to do?

1 Yes 2 No 7 R 8 DK

E. Bitter about the way your life has turned out?

1 Yes 2 No 7 R 8 DK

F. Generally satisfied with the way your life has turned out?

1 Yes 2 No 7 R 8 DK

The next section has to do with more general life experiences. Please answer “Yes or “No”.

G. I am just as happy as when I was younger.

1 Yes 2 No 7 R 8 DK

H. As I look back on my life I am fairly well satisfied.

1 Yes 2 No 7 R 8 DK

I. Things are getting worse as I get older.

1 Yes 2 No 7 R 8 DK

J. Little things bother me more this year.

1 Yes 2 No 7 R 8 DK

K. Life is hard for me most of the time.

1 Yes 2 No 7 R 8 DK

L. I am satisfied with my life today.

1 Yes 2 No 7 R 8 DK

22. Now, I am going to ask you a few questions about your financial situation. We would like to get an indication of the level of income and feeling of financial security that seniors have, and how this relates to other aspects of their lives. This is completely confidential and we will not be looking at individual data.

22a. How well do you think your income currently satisfies your needs? (Cue Card #10)

- 1 Very well
 - 2 Adequately
 - 3 With some difficulty
 - 4 Not very well
 - 5 Totally inadequate
 - 7 R
 - 8 DK
-

22b. Here is a list of numbered categories that correspond to various income levels. Think about your household income from all sources (for example, jobs, social security). Which category does your income fall into? (Cue Card #11)

- 1 2 3 4 5 6 7 8 9 10 11 12
 - 77 R 88 DK
-

23. In this study I have talked with many seniors and learned something from each one of them. What do you think makes people live long and keep well?

24. Now I'd like to ask you a few questions concerning your health care wishes.**A. Have you thought about who would make health treatment decisions for you if you were unable to do this for yourself? (For example, if you had to be put on a respirator)**1 Yes 2 No 7 R 8 DK**B. Who would you want to make health decisions for you if you were unable to do this for yourself? (Circle more than one if applicable: if 2 daughters, write '2' beside).**

1 Wife	11 Brother-in-law	23 Great granddaughter
2 Husband	12 Paid caregiver	24 Great grandson
3 Daughter	13 Volunteer	25 Niece's daughter
4 Son	16 Nephew	26 Niece's son
5 Sister	17 Niece	29 Institution's staff
6 Brother	18 Grandson	30 Family, unspecified
7 Friend	19 Granddaughter	
8 Daughter-in-law	20 Nephew's wife	90 Other <i>specify</i> :
9 Son-in-law	21 Niece's husband	_____
10 Sister-in-law	22 Cousin	

C. Have you discussed your preferences for end-of-life care with anyone?1 Yes 2 No 7 R 8 DK

(If Yes, please list who) 24 C.1 _____

(If No, R or DK, Skip to Q. 25)

D. Have you formalized this in a legal document? (For example, a living will or a Power of Attorney for Personal Care)1 Yes 2 No 7 R 8 DK**25. To complete our information, we would very much appreciate your consent to access information from (Name of Provincial Plan). Please remember, all information will be confidential as described in the consent form.**Consent given? 1 Yes 2 No**Thank you very much for your time.**

🕒 Time interview ended: ____ : ____ (24-hour clock)

