**Home Health & Hospice Family Caregiver Experience Survey**

Research shows that providing care for a loved one at home can provide both challenging and rewarding experiences for the caregiver and care recipient. This survey will ask you about your experiences as a caregiver as well some information about you, the person you care (or cared) for, and your relationship to him or her.

If you provide care for more than one person (*Example: your aging parent and your ill husband*), please choose one of them to respond to the questions of this survey. If you would like to respond about both caregiving experiences, please complete a second survey. You may pick up another copy of the survey from the agency that sent you this copy. Since we are not collecting names or hometowns, the information you provide will be completely anonymous.

**NOTE: This survey is printed on both sides of the paper. Please be sure to complete all the questions on each side.**

**TYPE OF CARE PROVIDED**

1. Please place a ✓ or X in the column that best describes how often you provide (or provided) these types of physical care:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Type of Physical Care:*** | ***Never*** | ***1 to 3 days a week*** | ***4 to 6 days a week*** | ***Every Day*** |
| ***EXAMPLE: Feeding*** |  |  | ***X*** |  |
| ***EXAMPLE: Dressing*** | ***✓*** |  |  |  |
| Feeding |  |  |  |  |
| Dressing |  |  |  |  |
| Bathing/showering |  |  |  |  |
| Grooming |  |  |  |  |
| Incontinence care |  |  |  |  |
| Mobility, walking assistance |  |  |  |  |
| Transfers (bed to chair, chair to toilet, etc.) |  |  |  |  |
| Give medications by mouth |  |  |  |  |
| Give medications by injection |  |  |  |  |
| Give suppositories (rectally or vaginally) |  |  |  |  |
| Apply skin preparations (patches, creams, ointments, etc.) |  |  |  |  |
| Give eye drops |  |  |  |  |
| Give ear drops |  |  |  |  |
| Give nasal sprays |  |  |  |  |
| Give/assist with breathing treatments |  |  |  |  |
| Ostomy care |  |  |  |  |
| Wound care |  |  |  |  |

***Please turn the page over and continue on Page 2.***

1. Please place a ✓ or X in the column that best describes how often you provide these types of household or supportive care:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Type of Household or Supportive Care:*** | ***Never*** | ***1 to 3 days a week*** | ***4 to 6 days a week*** | ***Every Day*** |
| ***EXAMPLE: Preparing meals*** | ***✓*** |  |  |  |
| ***EXAMPLE: Laundry*** |  | ***X*** |  |  |
| Preparing meals |  |  |  |  |
| Shopping/errands |  |  |  |  |
| Laundry |  |  |  |  |
| Housecleaning |  |  |  |  |
| Yard work/maintenance |  |  |  |  |
| Banking/bill paying, etc. |  |  |  |  |
| Providing transportation |  |  |  |  |
| Coordinating health care for care recipient |  |  |  |  |
| Coordinating social engagements for care recipient |  |  |  |  |
| Participating in medical appointments |  |  |  |  |
| Participating in social engagements (going to church with him/her, going to movies with him/her, etc.) |  |  |  |  |
| Entertaining the person you’re caring for by playing games with them, reading to them, etc. |  |  |  |  |

***Please continue to Page 3.***

**CAREGIVER PHYSICAL HEALTH**

1. This section is about **YOUR** physical health and any changes you have noticed during your caregiving experience. Please place a ✓ or X in the column that best describes how often you experience these physical symptoms:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Physical Health Item: | This is not a concern for me | No change during caregiving | Got worse during caregiving | Got better during caregiving |
| ***EXAMPLE: Trouble falling/staying asleep*** |  | ***✓*** |  |  |
| ***EXAMPLE: Physical strength*** |  |  |  | ***X*** |
| Trouble falling/staying asleep |  |  |  |  |
| Sleeping too much |  |  |  |  |
| Not sleeping enough |  |  |  |  |
| Eating/nutrition |  |  |  |  |
| Headaches |  |  |  |  |
| Backaches |  |  |  |  |
| Feeling tired |  |  |  |  |
| Medical condition (diabetes, heart problem, asthma, arthritis, etc.) |  |  |  |  |
| Use of prescription medications |  |  |  |  |
| Weight gain |  |  |  |  |
| Weight loss |  |  |  |  |
| Physical strength |  |  |  |  |
| Endurance/stamina |  |  |  |  |
| Ability to concentrate |  |  |  |  |

***Please turn the page over and continue on Page 4.***

**CAREGIVER EMOTIONAL HEALTH**

1. This section is about **YOUR** emotional health and any changes you noticed during your caregiving experience. Please place a ✓ or X in the column that best describes how often you experience these emotions:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Emotion: | Never | Rarely | Sometimes | Often | All the time |
| ***EXAMPLE: Exhausted*** |  | ***✓*** |  |  |  |
| ***EXAMPLE: Fulfilled*** | ***X*** |  |  |  |  |
| Angry |  |  |  |  |  |
| Anxious/nervous |  |  |  |  |  |
| Compassionate |  |  |  |  |  |
| Content/happy |  |  |  |  |  |
| Dependable/reliable |  |  |  |  |  |
| Depressed |  |  |  |  |  |
| Exhausted |  |  |  |  |  |
| Fearful |  |  |  |  |  |
| Fortunate |  |  |  |  |  |
| Frustrated |  |  |  |  |  |
| Fulfilled |  |  |  |  |  |
| Grateful |  |  |  |  |  |
| Guilty |  |  |  |  |  |
| Helpful |  |  |  |  |  |
| Helpless |  |  |  |  |  |
| Hopeful |  |  |  |  |  |
| Isolated, alone, lonely |  |  |  |  |  |
| Loving |  |  |  |  |  |
| Overwhelmed |  |  |  |  |  |
| Peaceful |  |  |  |  |  |
| Productive |  |  |  |  |  |
| Supportive |  |  |  |  |  |
| Unappreciated |  |  |  |  |  |
| Worried |  |  |  |  |  |

***Please continue to Page 5.***

**CAREGIVER** **PROFILE**

This information is about **YOU**. Since we are not collecting names or hometowns the information you provide will be completely anonymous.

1. Please choose one answer that best describes your gender:

* Female
* Male
* Prefer not to answer

1. Please choose the age range where you fit:

* 30 or under
* 31-50
* 51-65
* 66-75
* 76-85
* Over 85
* Prefer not to answer

1. Please choose your marital status:

* Divorced
* Domestic Partner
* Married
* Separated
* Single
* Widowed
* Prefer not to answer

1. Please choose the ethnicity/culture that you most identify as:

* African-American
* Asian-American
* Latino
* Mixed
* Native American
* White/Caucasian
* Prefer not to answer
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please turn the page over and continue on Page 6.***

1. I have the following medical issues (***please check all that apply***):

* Allergies
* Alzheimer’s disease
* Arthritis
* Bone Fracture (currently)
* Asthma
* Cancer
* Chronic obstructive pulmonary disorder
* Cirrhosis (liver disease)
* Dementia
* Depression
* Diabetes
* Heart failure or heart disease
* HIV or AIDS
* Parkinson’s Disease
* Renal (kidney) disease
* Stroke
* Substance Use/Abuse (alcohol or other drugs)
* Other medical concerns I have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. On most days, my physical health is:

* Excellent
* Good
* Fair
* Poor

1. On most days, my emotional health is:

* Excellent
* Good
* Fair
* Poor

1. I have been providing care for this person:

* Less than 6 months
* 6 months to 12 months
* More than 12 months

***Please continue to Page 7.***

**CARE RECIPIENT PROFILE**

This information is about **THE PERSON YOU PROVIDE CARE FOR**. Since we are not collecting names or hometowns the information you provide will be completely anonymous.

1. Please choose one answer that best describes his/her gender:

* Female
* Male
* Prefer not to answer

1. Please choose the age range where he/she fits:

* 30 or under
* 31-50
* 51-65
* 66-75
* 76-85
* Over 85
* Prefer not to answer

1. Please choose his/her marital status:

* Divorced
* Domestic Partner
* Married
* Separated
* Single
* Widowed
* Prefer not to answer

1. Please choose the ethnicity/culture that the person you care for most identifies as:

* African-American
* Asian-American
* Latino
* Mixed
* Native American
* White/Caucasian
* Prefer not to answer
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please turn the page over and continue on Page 8.***

1. This person is my:

* Aunt
* Brother
* Daughter
* Domestic Partner
* Father
* Father-in-Law
* Friend
* Grandfather
* Grandmother
* Husband
* Mother
* Mother-in-Law
* Sister
* Son
* Uncle
* Wife
* Other: Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. These are the medical issues affecting the person I provide care for (***please check all that apply***):

* Allergies
* Alzheimer’s disease
* Arthritis / Bone Fractures
* Asthma
* Cancer
* Chronic obstructive pulmonary disorder
* Cirrhosis (liver disease)
* Dementia
* Depression
* Diabetes
* Heart failure or heart disease
* HIV or AIDS
* Parkinson’s Disease
* Renal (kidney) disease
* Stroke
* Substance Use/Abuse (alcohol or other drugs)
* Other medical concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please continue to Page 9.***

**Thank you for taking the time to complete our survey.**

**We have provided an addressed, stamped envelope**

**for your convenience in returning your completed survey.**

**If the envelope has been misplaced,**

**please return the survey to your home care/hospice agency.**

**Please return your completed survey by March 15, 2012.**

**If you would like to know the results of our survey, please contact one of us below. Doing so will alert us only that you completed a survey. We will still have no way to connect you to any information provided.**

**Results will be available after May 15, 2012.**

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