



# Caregiver Self-Assessment Questionnaire

## How are you?

Caregivers are often so concerned with caring for their relative's needs that they lose sight of their own wellbeing. Please take just a moment to answer the following questions. Once you have answered the questions, turn the page to do a self-evaluation.

### During the past week or so, I have...

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- |   |   |
|---|---|
| 1. Had trouble keeping my mind on what I was doing ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         | 15. Been satisfied with the support my family has given me ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 2. Felt that I couldn't leave my relative alone..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             | 16. Found my relative's living situation to be inconvenient or a barrier to care ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   |
| 3. Had difficulty making decisions ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 17. On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful," please rate your current level of stress. _____                        |
| 4. Felt completely overwhelmed..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 18. On a scale of 1 to 10, with 1 being "very healthy" to 10 being "very ill," please rate your current health compared to what it was this time last year. _____ |
| 5. Felt useful and needed ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 6. Felt lonely ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 7. Been upset that my relative has changed so much from his/her former self..... <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 8. Felt a loss of privacy and/or personal time ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             | Comments:<br>(Please feel free to comment or provide feedback)  |
| 9. Been edgy or irritable ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____   |
| 10. Had sleep disturbed because of caring for my relative ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                  | _____   |
| 11. Had a crying spell(s) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____   |
| 12. Felt strained between work and family responsibilities..... <input type="checkbox"/> Yes <input type="checkbox"/> No                  | _____   |
| 13. Had back pain ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____   |
| 14. Felt ill ( <i>headaches, stomach problems or common cold</i> ) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | _____   |

