



ABUEL

**Questionnaire on Health and Well-being of People
between 60 and 84 Years**

This questionnaire was designed to assess living conditions, mental and physical health and relationships with others of people between 60 and 84 years.

Please write your country's name in the below row:

Country _____

Case number:

Please print the code of your country into COUNTRY-ID as follows: 30 (Greece), 34 (Spain), 35 (Portugal), 37 (Lithuania), 39 (Italy), 44 (UK), 46 (Sweden), 49 (Germany)

Country-ID		Person-ID		

Interview Date: // // (DD/MM/YY)

Interviewer ID: _____

MODE OF RECRUITMENT (Please tick one alternative)

-
- Municipal registers ₁
- Lists of older residents ₂
- Random Route ₃
- Other, please specify _____ ₄
-

MODE OF ADMINISTRATION (Please tick one alternative)

- | | |
|--------------------------|---------------------------------------|
| Self-administered | <input type="checkbox"/> ₁ |
| Interviewer-administered | <input type="checkbox"/> ₂ |

How to FILL IN this questionnaire

Most of the questions on the following pages can be filled in by simply checking the box below or alongside the answer that applies to the answer.*

<p>Please check ONE (1) box:</p> <p>Correct <input checked="" type="checkbox"/> or <input checked="" type="checkbox"/></p> <p>Incorrect <input type="checkbox"/></p>

Please tick one or several alternatives.

Please proceed question by question. Skip questions only if there is an explicit instruction to do so. Please stop the interview immediately in case the interviewee gets tired or upset.

<p><i>Example:</i></p> <p>Do you have children?</p> <p>Yes <input type="checkbox"/>_1 No <input type="checkbox"/>_2 <i>Go to question ...</i></p> <div style="display: flex; justify-content: space-around;"><div style="border: 1px solid gray; padding: 5px; width: 45%;"><p><i>If you tick "Yes" in this example, you go on to the next question!</i></p></div><div style="border: 1px solid gray; padding: 5px; width: 45%;"><p><i>If you tick "No" in this example, you go on to the question given in the instruction box!</i></p></div></div>
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For those questions the person is not willing to give an answer to, please do not write anything in the questionnaire and leave a blank.

PLEASE START THE QUESTIONNAIRE AT QUESTION 1 ON THE NEXT PAGE

PLEASE TELL: ALL ANSWERS WILL REMAIN CONFIDENTIAL.

*Comments for the interviewer are printed in *italic*

PART I

OBLIGATORY PART

Background

1. What is your year of birth _____ (year) or your age? _____ (years)

2. What is your sex? (Please tick one alternative)

Female ₁

Male ₂

3. Could you please tell me your height (cm)? _____ 4. Could you please tell me your weight (kg)? _____

5. What is your marital status? (Please tick one alternative)

Single ₁

Married/cohabitant ₂

Divorced/separated ₃

Widowed ₄

6. Where do you come from originally? (Please fill in all questions)

a) Please tell me your place of birth _____

b) Please tell me your country of birth _____

c) Which language is spoken at home most frequently? _____

d) What is your nationality? _____

7. With whom do you live? (Please tick one or several alternatives)

	Yes ▼ ₁	No ▼ ₂
a) Alone	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) My husband/wife/partner/cohabitant	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) My daughter	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) My son	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) My brother	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) My sister	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) My grandchild/ren	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
h) Paid personnel	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
j) Other person, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

8. Total number of persons living in your household, including paid personnel and yourself? _____

9. What is your education? (Please tick the highest alternative)

Cannot read nor write ₁

Without any degree ₂

Less than primary school ₃

Primary school/similar ₄

Secondary education/middle school/high school ₅

University/similar ₆

Other, please specify _____ ₇

10. What is/was your main profession? (Please ask for specification, and tick one alternative from the list below)

Managers (e.g. chief executives, administrative managers)	<input type="checkbox"/>	1
Professionals (e.g. science and engineering professionals, health professionals, teaching professionals)	<input type="checkbox"/>	2
Technicians and associate professionals (e.g. science and engineering associate professionals)	<input type="checkbox"/>	3
Clerical support workers (e.g. general and keyboard clerks, customer service clerks)	<input type="checkbox"/>	4
Service and sales workers (e.g. service and sales workers, personal care workers, sales workers)	<input type="checkbox"/>	5
Skilled agricultural, forestry and fishery workers (e.g. market-oriented skilled agricultural workers, subsistence farmers)	<input type="checkbox"/>	6
Craft and related trades workers (e.g. building and related trades workers, handicraft and printing workers)	<input type="checkbox"/>	7
Plant and machine operators, and assemblers (e.g. stationary plant and machine operators, assemblers)	<input type="checkbox"/>	8
Elementary occupations (e.g. cleaners and helpers, labourers in mining)	<input type="checkbox"/>	9
Housewife/househusband	<input type="checkbox"/>	10
Armed forces occupation (e.g. commissioned armed forces officers)	<input type="checkbox"/>	11

11. Do you still work (paid work)? (Please tick one alternative)

Yes	<input type="checkbox"/>	1	No	<input type="checkbox"/>	2	Go to question 15
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12. If you still work, how many hours do you work per week (paid work) approximately? (Please round up or down to the nearest hour; code as "1" for less than one hour)
_____ hours

13. If you still work, have you been on sick-leave the past year? (Please tick one alternative)

Yes	<input type="checkbox"/>	1
No	<input type="checkbox"/>	2

14. If you still work (paid work) have you been unemployed the past year? (Please tick one alternative)

Yes	<input type="checkbox"/>	1
No	<input type="checkbox"/>	2

15. If retired, since how long? _____ years

16. How long have you been unemployed totally in your life? (Please tick one alternative)

Never	<input type="checkbox"/>	1
12 months or less	<input type="checkbox"/>	2
More than 12 months	<input type="checkbox"/>	3

17. How many hours do you do unpaid work at home (e.g. cleaning, gardening) approximately per week? (Please round up or down to the nearest hour; code "1" for less than one hour) _____ hours

18. What is your present main source of financial support? (Please tick one alternative)

Work	<input type="checkbox"/>	1
Early retirement pension	<input type="checkbox"/>	2
Disability pension	<input type="checkbox"/>	3
Age pension	<input type="checkbox"/>	4
Sick-leave benefits	<input type="checkbox"/>	5
Unemployment benefits	<input type="checkbox"/>	6
Social help/social support benefits	<input type="checkbox"/>	7
Financial transfer by children	<input type="checkbox"/>	8
Financial transfer by relatives	<input type="checkbox"/>	9
Financial transfer by former partner	<input type="checkbox"/>	10
Widow/er pension	<input type="checkbox"/>	11
No financial support	<input type="checkbox"/>	12
Other, please specify _____	<input type="checkbox"/>	13

19. How often are you worried about the daily expenses? (e.g. for buying food) (Please tick one alternative)

Never	<input type="checkbox"/>	1
Quite often	<input type="checkbox"/>	2
Often	<input type="checkbox"/>	3
Always	<input type="checkbox"/>	4

20. Where do you live? (Please tick one alternative)

Own house	Own apartment	House renting	Apartment renting	Sheltered housing	Other, please specify
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ <input type="checkbox"/>
1	2	3	4	5	6

Life Style Factors

SMOKING

21. Do you smoke cigarettes? (Please tick one alternative)

Yes ₁

No ₂ **Go to question 25**

22. How often do you smoke cigarettes? (Please tick one alternative)

Once a month
or less

2-4 times a
month

2-3 times a
week

4 or more times
a week

₁

₂

₃

₄

23. How many cigarettes do you smoke on a typical smoking day? (Please tick one alternative)

1-2

3-5

6-9

10-20

More than
20

₁

₂

₃

₄

₅

24. How often do you have 10-20/more than 20 cigarettes on one occasion? (Please tick one alternative)

Never

Less than
monthly

Monthly

Weekly

Daily or
almost daily

₁

₂

₃

₄

₅

25. If you do not smoke now, have you ever smoked? (Please tick one alternative)

Yes

No

₁

₂

ALCOHOL USE

Could you please tell us whether you drink alcohol? (Explain what is meant by "alcohol" by using examples of e.g. beer, wine, vodka).

26. Do you drink alcohol? (Please tick one alternative)

Yes ₁

No ₂

Go to question 30

27. How often do you have a drink containing alcohol? (Please tick one alternative)

Once a month
or less

2-4 times a
month

2-3 times a
week

4 or more times
a week

₁

₂

₃

₄

28. How many drinks containing alcohol do you have on a typical day when you are drinking? (Please tick one alternative)

1 or 2

3 or 4

5 or 6

7, 8, or 9

10 or more

₁

₂

₃

₄

₅

29. How often do you have six or more drinks on one occasion? (Please tick one alternative)

Never

Less than
monthly

Monthly

Weekly

Daily or
almost daily

₁

₂

₃

₄

₅

30. If you do not drink alcohol now, have you ever been drinking alcohol? (Please tick one alternative)

	Yes	No
	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

DIET

31. How often do you eat... (Please tick one alternative in each question)

	Monthly				Weekly		Daily
	Never ▼ ₁	1 time or less ▼ ₂	2 to 4 times ▼ ₃	1 time ▼ ₄	2 to 3 times ▼ ₅	4 to 6 times ▼ ₆	▼ ₇
a) ...fruits or berries?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
b) ...vegetables?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
c) ...meat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
d) ...fish?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
e) ...dairy products?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
f) ...cereals (e.g. bread)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

32. Where do you have your meals and how often? (Please tick one alternative in each question)

	Monthly				Weekly		Daily
	Never ▼ ₁	1 time or less ▼ ₂	2 to 4 times ▼ ₃	1 time ▼ ₄	2 to 3 times ▼ ₅	4 to 6 times ▼ ₆	▼ ₇
a) At my home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
b) At other places, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

33. Who helps preparing/prepares your meals and how often? (Please tick one alternative in each question)

	Monthly				Weekly		Daily
	Never ▼ ₁	1 time or less ▼ ₂	2 to 4 times ▼ ₃	1 time ▼ ₄	2 to 3 times ▼ ₅	4 to 6 times ▼ ₆	▼ ₇
a) Self	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
b) Husband/wife/partner/cohabitant	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
c) Daughter	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
d) Son	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
e) Daughter-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
f) Son-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
g) Brother	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
h) Sister	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
j) Care staff, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
k) Other persons, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
l) I get my meals (e.g. meals on wheels)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

SOCIAL SUPPORT

Multidimensional Scale of Perceived Social Support (MSPSS)

34. Please rate each of the following questions on the 7-point scale (1=strongly disagree, 7=strongly agree).

	Very strongly disagree ▼ ₁	Strongly disagree ▼ ₂	Some- what disagree ▼ ₃	Neither agree nor disagree ▼ ₄	Some- what agree ▼ ₅	Strongly agree ▼ ₆	Very strongly agree ▼ ₇
a) There is a special person who is around when I am in need	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
b) There is a special person with whom I can share my joys and sorrows	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
c) My family really tries to help me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
d) I get the emotional help I need from my family	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
e) I have a special person who is a source of comfort to me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
f) My friends really try to help me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
g) I can count on my friends when things go wrong	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
h) I can talk about my problems with my family	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
j) I have friends with whom I can share joys and sorrows	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
k) There is a person in my life caring about my feelings	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
l) My family is willing to help me make decisions	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
m) I can talk about my problems with my friends	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

CARE SERVICES AND HEALTH CARE USE

35. Below there is a list of questions about care services and health care use in the past year. Have you been in contact with care services in the past year? (Please tick one alternative in each question)

Yes ₁

No ₂

Go to question 37

36. What care services have you used in the past year and how often? (Please tick one alternative in each question)

	Monthly			Weekly		Daily	
	Never ▼ ₁	1 time or less ▼ ₂	2 to 4 times ▼ ₃	1 time ▼ ₄	2 to 3 times ▼ ₅		4 to 6 times ▼ ₆
a) General practitioner	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
b) Medical specialist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
c) Nurse	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
d) Counsellor	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
e) Psychologist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
f) Social worker	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
g) Primary care	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
h) Day centre	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
j) Dentist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
k) Eye specialist	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
l) Hospital as an inpatient	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
m) Hospital as an outpatient	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
n) Other, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

37. Have you been in need of a certain care service in the past year, but did not seek help? (Please tick one alternative)

Yes ₁

No, I was not in need or if I was I sought for help

₂

Go to question 39

38. What were the reasons for not using care services? (Please tick one alternative in each question.)

	Yes ▼ ₁	No ▼ ₂
a) The problems disappeared	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) The waiting-list was too long	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) The care services were difficult to contact	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) The care services were not available	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) I did not get an appointment fast enough	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) I had negative experience from previous services	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) I had financial problems	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
h) I did not have the time	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
j) I did not know who to contact	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
k) Other reasons, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

39. How often are you worried about the expenses for health care? (e.g. for prescriptions for medication) (Please tick one alternative)

Never	<input type="checkbox"/>
Quite often	<input type="checkbox"/>
Often	<input type="checkbox"/>
Always	<input type="checkbox"/>

40. If you have been in contact with/received caring services at the hospital, in primary care, or private surgery or similar during the past year, how satisfied have you been with their service? (Please tick one alternative)

	Not satisfied at all	Slightly satisfied	Moderately satisfied	Quite a bit satisfied	Very satisfied
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DISEASES

41. Below there is a list of diseases. Do you suffer from ...? (Please tick one alternative in each question)

	Yes ▼ ₁	No ▼ ₂	Earlier „yes“, not now ▼ ₃
a) Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Eye diseases (e.g. cataracts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Cardiovascular diseases (e.g. high blood-pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Liver diseases (e.g. Hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Stomach/bowel diseases (e.g. ulcer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Lung diseases (e.g. Chronic obstructive lung disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Cancer, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Other diseases, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

42. For each of the above diseases you are suffering from at present please tell us, how bothered are you by this specific disease? (Please tick one alternative in each question)

	Not at all ▼ ₁	Slightly ▼ ₂	Somewhat ▼ ₃	Considerably ▼ ₄	Very much ▼ ₅
a) Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Eye diseases (e.g. cataracts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Cardiovascular diseases (e.g. high blood-pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Liver diseases (e.g. Hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Stomach/bowel diseases (e.g. ulcer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Lung diseases (e.g. Chronic obstructive lung disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Cancer, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Other diseases, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

USE OF MEDICATION

43. Below there is a list of medications. If you use any of these, how often do you use it? (Please tick one alternative in each question)

	No ▼ ₁	At need ▼ ₂	Regularly ▼ ₃	Daily ▼ ₄
a) Pain medication	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b) Sleep medication	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c) Medication for depression	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d) Medication for anxiety	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
e) Medication for psychosis	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
f) Medication for Allergy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
g) Medication for Asthma	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
h) Medication for the heart	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
j) Medication for diabetes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
k) Other Medication, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
l) Natural and herbal medication (e.g. homeopathy)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

44. Who helps with the medication? (Please tick one alternative in each question)

	No ▼ ₁	At need ▼ ₂	Regularly ▼ ₃	Daily ▼ ₄
a) I do it myself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b) My husband/wife/cohabitant does it	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c) My daughter/son does it	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d) Other relatives do it (please specify) _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
e) Caring staff do it	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
f) Other people do it (please specify) _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

45. Have you ever refrained from buying prescript medication and care? (Please tick one alternative)

Yes <input type="checkbox"/> ₁	No <input type="checkbox"/> ₂ Go to question 47
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46. What were the reasons for not buying prescript medication and care? (Please tick one alternative in each question)

	Yes ▼ ₁	No ▼ ₂
a) The problems disappeared	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) I was afraid of the side effects	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) Negative experiences from previous medication	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) Financial problems	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) I did not have the time	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) Other reasons, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

PHYSICAL HEALTH / QUALITY of LIFE / DEPRESSION / ANXIETY

PHYSICAL HEALTH

Giessen Complaint Questionnaire (GQB-24)

47. The list below contains a number of bodily complaints. Please consider which of these complaints you currently have and tick each one alternative in each question to show how much discomforts you. (Please tick only one box from "1" through "5" in each row)

	Not at all ▼ ₁	Slightly ▼ ₂	Some- what ▼ ₃	Consider- ably ▼ ₄	Very much ▼ ₅
a) Physical weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Heavy, rapid or irregular heart-throbbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Pressure or heaviness in the stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Excessive need for sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Pains in joints or limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Pains in neck or shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Sensation of tightness, choking or lumpiness in the throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Belching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Tendency to rapid exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Tiredness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) Feeling numb or benumbed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) Heaviness or tiredness in the legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) Weariness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u) Twinges, pains or aching in the chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v) Stomach-aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w) Attacks of breathlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x) Head-pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y) Sudden bouts of heart-trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

QUALITY OF LIFE

World Health Organisation Quality of Life - Old (WHOQOL-OLD)

48. The following questions are about how you would estimate your quality of life (Please tick one alternative in each question)

	Not at all ▼ ₁	Slightly ▼ ₂	Moderately ▼ ₃	Very much ▼ ₄	Extremely ▼ ₅
a) To what extent do impairments to your senses (e.g. hearing, vision, taste, smell, touch) affect your daily life?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
b) To what extent does loss of for example, hearing, vision, taste, smell or touch, affect your ability to participate in activities?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
c) How much freedom do you have to make your own decisions?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
d) To what extent do you feel in control of your future?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
e) How much do you feel that the people around you are respectful of your freedom?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
f) How much are you concerned about the way in which you will die?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
g) How much are you afraid of not being able to control your death?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
h) How scared are you of dying?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
j) How much do you fear being in pain before you die	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

The following questions ask about how completely you experience or were able to do certain things in the last two weeks, for example getting out as much as you would like to. Questions refer to the last two weeks.

	Not at all ▼ ₁	A little ▼ ₂	Moderately ▼ ₃	Mostly ▼ ₄	Completely ▼ ₅
k) To what extent do problems with your sensory functioning (e.g. hearing, vision, taste, smell, touch) affect your ability to interact with others?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
l) To what extent are you able to do the things you'd like to do?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
m) To what extent are you satisfied with your opportunities in life?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
n) How much do you feel that you have received the recognition you deserve in life?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
o) To what extent do you feel that you have enough to do each day?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

The following questions ask you to say how satisfied, happy or good you have felt about various aspects of your life over the last two weeks, for example, about your participation in community life or your achievements in life. Questions refer to the last two weeks.

	Very dissatisfied ▼ ₁	Dissatisfied ▼ ₂	Neither sa- tisfied nor dissatisfied ▼ ₃	Satisfied ▼ ₄	Very satisfied ▼ ₅
p) How satisfied are you with what you have achieved in life?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
q) How satisfied are you with the way you use your time?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
r) How satisfied are you with your level of activity?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
s) How satisfied are you with your opportunity to participate in community activities?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

	Very unhappy ▼ ₁	Unhappy ▼ ₂	Neither happy nor unhappy ▼ ₃	Happy ▼ ₄	Very happy ▼ ₅
t) How happy are you with the things you are able to look forward to?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

	Very poor ▼ ₁	Poor ▼ ₂	Neither poor nor good ▼ ₃	Good ▼ ₄	Very good ▼ ₅
u) How would you rate your sensory functioning (e.g. hearing, vision, taste, smell, touch)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

The following questions refer to any intimate relationships that you may have. Please consider these questions with reference to a close partner or other close person with whom you can share intimacy more than with any other person in your life.

	Not at all ▼ ₁	A little ▼ ₂	A moderate amount ▼ ₃	Very much ▼ ₄	An extreme amount ▼ ₅
v) To what extent do you feel a sense of companionship in your life?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
w) To what extent do you experience love in your life?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

	Not at all ▼ ₁	A little ▼ ₂	Moderately ▼ ₃	Mostly ▼ ₄	Completely ▼ ₅
x) To what extent do you have opportunities to love?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
y) To what extent do you have opportunities to be loved?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

DEPRESSION / ANXIETY

Hospital Anxiety and Depression Scale (HADS)

49. Below you find a list of statements how you feel. (Please tick one alternative in each question)

	Most of the time	A lot of the time	From time to time, occasionally	Not at all
a) I feel tense or 'wound up'	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
	Definitely as much	Not quite so much	Only a little	Hardly at all
b) I still enjoy the things I used to enjoy	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Very definitely and quite badly	Yes, but not too badly	A little, but it doesn't worry me	Not at all
c) I get a sort of frightened feeling as if something awful is about to happen	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
	As much as I always could	Not quite so much now	Definitely not so much now	Not at all
d) I can laugh and see the funny side of things	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	A great deal of the time	A lot of the time	Not too often	Very little
e) Worrying thoughts go through my mind	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
	Never	Not often	Sometimes	Most of the time
f) I feel cheerful	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
	Definitely	Usually	Not often	Not at all
g) I can sit at ease and feel relaxed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Nearly all the time	Very often	Sometimes	Not at all
h) I feel as if I am slowed down	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
	Not at all	Occasionally	Quite often	Very often
j) I get a sort of frightened feeling like 'butterflies' in the stomach	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	I take just as much care as ever	I may not take quite as much care	I don't take as much care as I should	Definitely
k) I have lost interest in my appearance	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Very much indeed	Quite a lot	Not very much	Not at all
l) I feel restless as if I have to be on the move	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
	As much as I ever did	Rather less than I used to	Definitely less than I used to	Hardly at all
m) I look forward with enjoyment to things	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
	Very often indeed	Quite often	Not very often	Not at all
n) I get sudden feelings of panic	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
	Often	Sometimes	Not often	Very seldom
o) I can enjoy a good book or radio or television programme	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

VIOLENCE / ABUSE / NEGLECT

PSYCHOLOGICAL VIOLENCE

50. Below there is a list of events which deal with psychological violence that you may have been exposed to. How many times have you been exposed to each of these events in the past year? (If the person has not been exposed to these events the past year but it happened before that, mark "7." If these things have never happened the past year, mark "8")

Someone has...

HOW MANY TIMES?

1 = Once in the past year

2 = Twice in the past year

3 = 3-5 times in the past year

4 = 6-10 times in the past year

5 = 11-20 times in the past year

6 = More than 20 times in the past year, happen before

7 = Not in the past year, but happened before

8 = This has never happened

	Once in the past year ▼ ₁	Twice in the past year ▼ ₂	3-5 times in the past year ▼ ₃	6-10 times in the past year ▼ ₄	11-20 times in the past year ▼ ₅	More than 20 times in the past year ▼ ₆	Not in past year, but before ▼ ₇	This has never happened ▼ ₈
a) ... insulted you or sworn at you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) ... threatened you (e.g. putting you in a nursing home, breaking things that you care about)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) ... undermined or belittled what you do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) ... excluded you or repeatedly ignored you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) ... threatened to harm others that you care about (e.g. pets, relatives)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) ... prevented you from seeing others that you care about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) ...shouted or yelled at you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) ...did something to spite you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) ...called you fat, ugly or other names	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) ... destroyed something that belonged to you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) ... threatened to hit or throw something at you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If all items in question 50 have been answered with "This has never happened" please go to question 55.

51. Who did these things? Please tick whether this person lives with you and how old this person is (Please tick one or several persons, how often they did the things, whether the person lives with you and their age)

	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	More than 20 times in the past year	Not in the past year, but before	This has never hap- pened	Does this person live with you?		If abused, please specify the age of this person
	▼ ₁	▼ ₂	▼ ₃	▼ ₄	▼ ₅	▼ ₆	▼ ₇	▼ ₈	Yes ▼ ₈₁	No ▼ ₈₂	
	Column 1								Column 2		Column 3
a) Husband/wife/ partner/cohabitant	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
b) Daughter	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
c) Son	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
d) Daughter-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
e) Son-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
f) Sister	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
g) Brother	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
h) Grandchild (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
j) Grandchild (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
k) Other relative (female), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
l) Other relative (male), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
m) Friend (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
n) Friend (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
o) Acquaintance (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
p) Acquaintance (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
q) Neighbour (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
r) Neighbour (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
s) Other person(s) (female), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
t) Other person(s) (male), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____

52. Where did these events happen? Below there is a list of places where the things you have been exposed to may have occurred *(Please tick or several places where the things may have occurred)*

	Yes ▼ ₁	No ▼ ₂
a) In my home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Other persons home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) In the assisted living home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) In the street	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) In public transportation (e.g. busses)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) In a restaurant, pub or coffee-shop	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) In a shop (e.g. where I buy my groceries)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
h) Other places, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

53. How did you react to these events? Below there is a list of reactions you may have had following the events you have been exposed to *(Please tick one or several reactions or no reaction)*

	Yes ▼ ₁	No ▼ ₂
a) Verbally, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Physically, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) Emotionally (e.g. angry, upset)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) Reported the incidents, please specify to whom _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) Walked away	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) Other reaction, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) Did not react	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

54. Were you affected by these events? Below there is a list of experiences/ feelings you may have had after being exposed to the events *(Please tick how affected you were)*

	Not at all ▼ ₁	Somewhat ▼ ₂	Moderately ▼ ₃	Considerably ▼ ₄
a) I felt cut off from family or friends	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b) I felt angry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c) I felt frightened	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d) I felt upset	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
e) I felt ashamed	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
f) Other feelings, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

PHYSICAL VIOLENCE

55. How many times have these events dealing with physical violence happened to you in the past year?
(Please tick how many times the person has been exposed to each of these events in the past year) Someone has...

	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	More than 20 times in the past year	Not in the past year, but before	This has never hap- pened
	▼ ₁	▼ ₂	▼ ₃	▼ ₄	▼ ₅	▼ ₆	▼ ₇	▼ ₈
a) ...slapped you	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
b) ...grabbed you	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
c) ...kicked you	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
d) ...pushed or shoved you	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
e) ...burned or scalded you on purpose	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
f) ... choked you	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
g) ... threw something at you that hurt	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
h) ... twisted your arm or hair	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
j) ... used a knife, a gun or other weapon on you	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
k) ... punched or hit you with something that could hurt	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
l) ... slammed you against a wall, door or a piece of furniture	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
m) ... beat you up	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
n) ... tied you down	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
o) ... restrained you in any other way	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
p) ... locked you in your room	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
q) ... gave you drugs or too much medicine to control you/ make you docile	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
r) ... threatened you with knife, a gun or other weapon	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

If all items in question 55 been answered with "This has never happened" please go to question 60.

56. Who did these things? (Please indicate one or several persons, how often they did the things, whether the persons live with you and how old the persons are)

	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	More than 20 times in the past year	Not in the past year, but before	This has never hap- pened	Does this person live with you?		If abused, please specify the age of this person
	▼ ₁	▼ ₂	▼ ₃	▼ ₄	▼ ₅	▼ ₆	▼ ₇	▼ ₈	Yes ▼ ₈₁	No ▼ ₈₂	
	Column 1								Column 2		Column 3
a) Husband/wife/ partner/cohabitant	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
b) Daughter	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
c) Son	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
d) Daughter-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
e) Son-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
f) Sister	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
g) Brother	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
h) Grandchild (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
i) Grandchild (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
k) Other relative (female), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
l) Other relative (male), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
m) Friend (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
n) Friend (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
o) Acquaintance (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
p) Acquaintance (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
q) Neighbour (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
r) Neighbour (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
s) Other person(s) (female), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
t) Other person(s) (male), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____

57. Where did these things happen? Below there is a list of places where the things you have been exposed to may have occurred *(Please tick or several places where the things may have happen)*

	Yes ▼ ₁	No ▼ ₂
a) In my home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Other persons home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) In the assisted living home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) In the street	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) In public transportation (e.g. busses)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) In a restaurant, pub or coffee-shop	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) In a shop (e.g. where I buy my groceries)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
h) Other places, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

58. How did you react to these events? Below there is a list of reactions you may have had following the events you have been exposed to *(Please tick one or several reactions or no reaction)*

	Yes ▼ ₁	No ▼ ₂
a) Verbally, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Physically, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) Emotionally (e.g. angry, upset)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) Reported the incidents, please specify to whom _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) Walked away	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) Other reaction, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) Did not react	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

59. Were you affected by these things? Below there is a list of experiences/ feelings you may have had after being exposed for the things *(Please tick how affected you were)*

	Not at all ▼ ₁	Somewhat ▼ ₂	Moderately ▼ ₃	Considerably ▼ ₄
a) I felt cut off from family or friends	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b) I felt angry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c) I felt frightened	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d) I felt upset	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
e) I felt ashamed	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
f) Other feelings, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

PHYSICAL INJURY

60. How many times did these things happen to you in the past year? (Please tick how many times the person has been exposed to each of these events in the past year)

	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	More than 20 times in the past year	Not in the past year, but before	This has never happened
	▼ ₁	▼ ₂	▼ ₃	▼ ₄	▼ ₅	▼ ₆	▼ ₇	▼ ₈
a) You had a sprain, bruise or small cut from being hit etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) You passed out from being hit on the head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) You went to the doctor from being hit etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) You needed to go to the doctor from being hit etc, but did not	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) You had a broken bone from being hit etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) You felt a physical pain that still hurt the next day from being hit etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Other injury, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If all items in question 60 been answered with "This has never happened" please go to question 65.

61. Who did these things? (Please tick one or several persons, how often they did the things, whether the persons live with you and how old they are)

	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	More than 20 times in the past year	Not in the past year, but before	This has never hap- pened	Does this person live with you?		If abused, please specify the age of this person
	▼ ₁	▼ ₂	▼ ₃	▼ ₄	▼ ₅	▼ ₆	▼ ₇	▼ ₈	Yes ▼ ₈₁	No ▼ ₈₂	
	Column 1								Column 2		Column 3
a) Husband/wife/ partner/cohabitant	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
b) Daughter	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
c) Son	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
d) Daughter-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
e) Son-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
f) Sister	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
g) Brother	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
h) Grandchild (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
i) Grandchild (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
k) Other relative (female), specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
l) Other relative (male), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
m) Friend (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
n) Friend (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
o) Acquaintance (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
p) Acquaintance (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
q) Neighbour (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
r) Neighbour (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
s) Other person(s) (female), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
t) Other person(s) (male), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____

62. Where did these things happen? (Please tick one or several places where the things may have happen)

	Yes ▼ ₁	No ▼ ₂
a) In my home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Other persons home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) In the assisted living home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) In the street	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) In public transportation (e.g. busses)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) In a restaurant, pub or coffee-shop	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) In a shop (e.g. where I buy my groceries)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
h) Other places, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

63. How did you react to these things? Below there is a list of reactions you may have had following the things you have been exposed to (Please tick one or several reactions or no reaction)

	Yes ▼ ₁	No ▼ ₂
a) Verbally, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Physically, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) Emotionally (e.g. angry, upset)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) Reported the incidents, please specify to whom _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) Walked away	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) Other reaction, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) Did not react	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

64. Were you affected by these things? Below there is a list of experiences/feelings you may have had after being exposed for the things (Please tick how affected you were)

	Not at all ▼ ₁	Somewhat ▼ ₂	Moderately ▼ ₃	Considerably ▼ ₄
a) I felt cut off from family or friends	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b) I felt angry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c) I felt frightened	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d) I felt upset	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
e) I felt ashamed	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
f) Other feelings, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

FINANCIAL MALTREATMENT

65. How many times have these things happened to you in the past year? Someone has / some people have... *(Please tick how many times the person has been exposed to each of these events in the past year)*

	Once in the past year ▼ ₁	Twice in the past year ▼ ₂	3-5 times in the past year ▼ ₃	6-10 times in the past year ▼ ₄	11-20 times in the past year ▼ ₅	More than 20 times in the past year ▼ ₆	Not in the past year, but it did happen before ▼ ₇	This has never hap- pened ▼ ₈
a) ... made you give him/them your money, possessions or property against your will	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) ... tried to make you give money, possessions or property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) ... tried to use fraud to take money, possessions or property from you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) ... tried to take or keep power of attorney against your will	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) ... attempted to steal money, possessions or property from you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) ... stolen money, possessions or property from you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) ... used fraud to take your money, possessions or property from you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) ... took or kept power of attorney over you against your will	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) ... did something else to take your money, possessions or property from you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If all items in question 65 have been answered with “This has never happened” please go to question 70.

66. Who did these things? (Please tick one or several persons, how often they did the things, whether the persons live with you and how old they are)

	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	More than 20 times in the past year	Not in the past year, but before	This has never hap- pened	Does this person live with you?		If abused, please specify the age of this person
	▼ ₁	▼ ₂	▼ ₃	▼ ₄	▼ ₅	▼ ₆	▼ ₇	▼ ₈	Yes ▼ ₈₁	No ▼ ₈₂	
	Column 1								Column 2		Column 3
a) Husband/wife/ partner/cohabitant	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
b) Daughter	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
c) Son	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
d) Daughter-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
e) Son-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
f) Sister	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
g) Brother	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
h) Grandchild (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
i) Grandchild (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
k) Other relative (female), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
l) Other relative (ma- le), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
m) Friend (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
n) Friend (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
o) Acquaintance (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
p) Acquaintance (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
q) Neighbour (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
r) Neighbour (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
s) Other person(s) (female), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
t) Other person(s) (male), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____

67. Where did these things happen? (Please tick one or several places where the things may have happen)

	Yes ▼ ₁	No ▼ ₂
a) In my home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Other persons home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) In the assisted living home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) In the street	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) In other places, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

68. How did you react to these things? Below there is a list of reactions you may have had following the things you have been exposed to *(Please tick one or several reactions or no reaction.)*

	Yes ▼ ₁	No ▼ ₂
a) Ignored what happened	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Confronted the person(s)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) Emotionally (e.g. angry, upset)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) Reported the incident(s), please specify to whom _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) Other reaction, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) Did not react	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

69. Were you affected by these things? Below there is a list of experiences/feelings you may have had after being exposed to these things *(Please tick how affected you were)*

	Not at all ▼ ₁	Somewhat ▼ ₂	Moderately ▼ ₃	Considerably ▼ ₄
a) I felt cut off from family or friends	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b) I felt angry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c) I felt frightened	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d) I felt upset	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
e) I felt ashamed	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
f) Caused economic problems	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
g) Other feelings, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

SEXUAL VIOLENCE

70. How many times have these things happened to you the past year? *(Please tick how many times the person has been exposed to each of these events in the past year)*

	Once in the past year ▼ ₁	Twice in the past year ▼ ₂	3-5 times in the past year ▼ ₃	6-10 times in the past year ▼ ₄	11-20 times in the past year ▼ ₅	More than 20 times in the past year ▼ ₆	Not in the past year, but before ▼ ₇	This has never happened ▼ ₈
a) ... talked to you in a sexual way	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
b) ... touched you in a sexual way against your will	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
c) ... tried to touch you in a sexual way against your will	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
d) ... made you watch pornography against your will	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
e) ... tried to make you watch pornography against your will	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
f) ... had sexual intercourse with you against your will	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
g) ... tried to have sexual intercourse with you against your will	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈
h) Other sexual molesting behaviours	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈

If all items in question 70 have been answered with "This has never happened" please go to question 75.

71. Who did these things? (Please tick one or several persons, how often they did the things, whether the persons live with you and how old they are)

	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	More than 20 times in the past year	Not in the past year, but before	This has never hap- pened	Does this person live with you?		If abused, please specify the age of this person
	▼ ₁	▼ ₂	▼ ₃	▼ ₄	▼ ₅	▼ ₆	▼ ₇	▼ ₈	Yes ▼ ₈₁	No ▼ ₈₂	
	Column 1								Column 2		Column 3
a) Husband/wife/ partner/cohabitant	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
b) Daughter	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
c) Son	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
d) Daughter-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
e) Son-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
f) Sister	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
g) Brother	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
h) Grandchild (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
i) Grandchild (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
k) Other relative (female), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
l) Other relative (male), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
m) Friend (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
n) Friend (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
o) Acquaintance (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
p) Acquaintance (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
q) Neighbour (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
r) Neighbour (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
s) Other person(s) (female), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
t) Other person(s) (male), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____

72. Where did these things happen? Below there is a list of places where the things you have been exposed to may have occurred *(Please tick or several places where the things may have happen)*

	Yes ▼ ₁	No ▼ ₂
a) In my home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Other persons home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) In the assisted living home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) In the street	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) In public transportation (e.g. busses)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) In a restaurant, pub or coffee-shop	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) In a shop (e.g. where I buy my groceries)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
h) Other places, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

73. How did you react to these things? Below there is a list of reactions you may have had following the things you have been exposed to *(Please tick one or several reactions or no reaction)*

	Yes ▼ ₁	No ▼ ₂
a) Verbally, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Physically, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) Emotionally (e.g. angry, upset)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) Reported the incidents, please specify to whom _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) Walked away	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) Other reaction, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) Did not react	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

74. Were you affected by these things (sexual violence)? Below there is a list of experiences/feelings you may have had after being exposed for the things *(Please tick how affected you were)*

	Not at all ▼ ₁	Somewhat ▼ ₂	Moderately ▼ ₃	Considerably ▼ ₄
a) I felt cut off from family or friends	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b) I felt angry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c) I felt frightened	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d) I felt ashamed	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
e) I felt upset	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
f) Other feelings, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

NEGLECT

75. Below there is a list of activities that you may have needed help with in the last year. Tick whether you needed help and received help, or whether you needed help but did not receive help or whether you did not need help. (Please tick in each row)

	Yes, needed and have received help ▼ ₁	Yes, needed help, but have not received help ▼ ₂	No help needed ▼ ₃
a) Shopping groceries, clothes or other things	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b) Preparing meals	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c) Doing routine housework	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d) Travel or transport	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e) Getting in and out of bed	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
f) Washing or bathing (including getting in and out of bath or shower)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
g) Dressing or undressing	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
h) Eating, including cutting up food	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
j) Getting to and using toilet	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
k) Help with correct dose and timing of medication	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
l) Any other day-to-day activity, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
m) Other household activities (e.g. gardening)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
n) General mobility in the house/caring-home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

If none of the above items in question 75 have been answered with “yes, needed and received help” please go to question 77. If none of the items in question 75 have been answered with “yes, needed help, but not received help” please do not ask the questions 77-81. If all items in question 75 have been answered with “no help needed”, please go to question 82.

76. Who helped you? Thinking about the activities you needed and received help with, who did it? (Please tick one or several alternatives)

	Yes ▼ ₁	No ▼ ₂
a) Husband/wife/partner/cohabitant	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Daughter	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) Son	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) Daughter-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) Son-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) Sister	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) Brother	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
h) Grandchild (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
j) Grandchild (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
k) Other relative (female), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
l) Other relative (male), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
m) Friend (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
n) Friend (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
o) Acquaintance (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

p) Acquaintance (male)	<input type="checkbox"/> _1	<input type="checkbox"/> _2
q) Neighbour (female)	<input type="checkbox"/> _1	<input type="checkbox"/> _2
r) Neighbour (male)	<input type="checkbox"/> _1	<input type="checkbox"/> _2
s) Other persons (female), please specify _____	<input type="checkbox"/> _1	<input type="checkbox"/> _2
t) Other persons (male), please specify _____	<input type="checkbox"/> _1	<input type="checkbox"/> _2

77. Who did not help you? Thinking about the activities you needed help with, who refrained from helping you and how often in the past year? (Please tick one or several alternatives.)

	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	More than 20 times in the past year	Not in the past year, but before	This has never hap- pened	Does this person live with you?		If abused, please specify the age of this person
	▼ ₁	▼ ₂	▼ ₃	▼ ₄	▼ ₅	▼ ₆	▼ ₇	▼ ₈	Yes ▼ ₈₁	No ▼ ₈₂	▼
	Column 1								Column 2		Column 3
a) Husband/wife/ partner/cohabitant	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
b) Daughter	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
c) Son	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
d) Daughter-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
e) Son-in-law	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
f) Sister	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
g) Brother	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
h) Grandchild (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
i) Grandchild (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
k) Other relative (female), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
l) Other relative (male), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
m) Friend (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
n) Friend (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
o) Acquaintance (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
p) Acquaintance (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
q) Neighbour (female)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
r) Neighbour (male)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
s) Other person(s) (female), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____
t) Other person(s) (male), please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈₁	<input type="checkbox"/> ₈₂	_____

78. Where did these things happen? (Please tick one or several places where the things may have happen)

	Yes ▼ ₁	No ▼ ₂
a) In my home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Other persons home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) In the assisted living home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) In other places, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

79. Why did you not get help? Below there is a list of reasons why you did not get help (Please tick one or several reasons)

	Yes ▼ ₁	No ▼ ₂
a) Carer (e.g. relative) at work	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Carer (e.g. relative) ill	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) Carer (e.g. relative) on holiday	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) Carer (e.g. relative) forgot	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) Carer (e.g. relative) busy/unavailable	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) I did not ask for help	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) I did not know the reason	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
h) Other reason, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

80. How did you react? Below there is a list of reactions you may have had because you needed help and did not receive (Please tick one or several reactions)

	Yes ▼ ₁	No ▼ ₂
a) Physically, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Emotionally (e.g. angry, upset)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) Other reaction, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) Did not react	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

81. Were you affected? Below there is a list of experiences/feelings you may have had because you needed help and did not receive (Please tick how affected you were)

	Not at all ▼ ₁	Somewhat ▼ ₂	Moderately ▼ ₃	Considerably ▼ ₄
a) I felt cut off from family or friends	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b) I felt angry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c) I felt frightened	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d) I felt upset	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
e) I felt ashamed	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
f) I felt discomfort	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
g) I felt hunger	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
h) Other feelings, please specify _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

LEISURE ACTIVITIES

82. How often do you practice these activities? (Please tick one alternative in each question)

	Never	Monthly		Weekly		Daily	
	▼ ₁	1 time or less ▼ ₂	2 to 4 times ▼ ₃	1time ▼ ₄	2 to 3 times ▼ ₅	4 to 6 times ▼ ₆	▼ ₇
a) Sewing, knitting, gardening, collecting things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Listening to music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Meeting family/ family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Looking after grandchildren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Social activities (e.g. meeting friends)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Religious activities (e.g. in churches)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Activities outside home (e.g. going to cinemas or theatres)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Taking exercises (e.g. walking, swimming)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Artistic activity (e.g. painting, playing musical instruments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Travelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Other hobby, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RELIGION

83. Do you consider yourself a religious person? (Please tick one alternative)

	Not at all ▼ ₁	Somewhat ▼ ₂	Moderately ▼ ₃	Considerably ▼ ₄
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you do not consider yourself a religious person, please go to question 85

84. If you consider yourself a religious person: What religion do you belong to or feel attached to? (Please tick one alternative from the list below)

Protestant	<input type="checkbox"/>
Catholic	<input type="checkbox"/>
Orthodox	<input type="checkbox"/>
Jewish	<input type="checkbox"/>
Moslem	<input type="checkbox"/>
Other (please specify): _____	<input type="checkbox"/>

85. Do you have any comments on the questions or would you like to tell us something?

II

OPTIONAL PART OF QUESTIONNAIRE

86. How would you rate your total family income resulting from your family earnings, salaries, income from self-employment, age/ retirement pension, each after taxes and social-insurance contributions? (Please tick.)

<i>< 1000</i>	<input type="checkbox"/> ₁
1001 - 1500	<input type="checkbox"/> ₂
1501 - 2000	<input type="checkbox"/> ₃
2001 - 2500	<input type="checkbox"/> ₄
2501 - 3000	<input type="checkbox"/> ₅
> 3000	<input type="checkbox"/> ₆
I do not know	<input type="checkbox"/> ₇
I do not want to disclose	<input type="checkbox"/> ₈

87. The following questions are about accommodation. Does your accommodation have... (Please tick one or several alternatives.)

	Yes ▼ ₁	No ▼ ₂
a) ...an indoor bath or shower only for your household's personal use	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) ...an indoor flushing toilet only for your household's personal use	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) ...heating system	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) ...a balcony, terrace or garden	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

88. Further, with respect to your accommodation, would you say it... (Please tick one or several alternatives.)

	Yes ▼ ₁	No ▼ ₂
a) ...has not enough space	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) ...costs too much <i>in relation to the money I have to spend for daily living</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) ...has not enough light	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) ...has insufficient heating or cooling facilities	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

89. And about the area immediately surrounding your accommodation, would you say it ... (Please tick one or several alternatives.)

	Yes ▼ ₁	No ▼ ₂
a) ...has sufficient supply of facilities such as pharmacy, medical care, grocery and the like within reasonable distance	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) ...has sufficient possibilities for public transportation	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) ...has pollution, noise or other environmental problems	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) ...suffers from vandalism or crime	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

STRESSFUL LIFE EVENTS

Stressful Life Events Screening Questionnaire

90. The items listed below refer to events that may have taken place at any point in your entire life, including early childhood. (Please tick.)

	Yes ▼ ₁	No ▼ ₂
a) Have you ever had a life-threatening illness?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Were you ever in a life-threatening accident?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) Was physical force or a weapon ever used against you in a robbery or mugging?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) Has an immediate family member, romantic partner, or very close friend died because of accident, homicide, or suicide?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) At any time, has anyone (parent, other family member, romantic partner, stranger or someone else) ever physically forced you to any kind of sexual activity?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) When you were a child, did a parent, caregiver or other person ever slap you repeatedly, beat you, or otherwise attack or harm you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) As an adult, have you ever been kicked, beaten, slapped around or otherwise physically harmed by a romantic partner, date, family member, stranger, or someone else?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
h) Has a parent, romantic partner, or family member repeatedly ridiculed you, put you down, ignored you, or told you were no good?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
j) Other than the experiences already covered, has anyone ever threatened you with a weapon like a knife or gun?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
k) Have you ever been present when another person was killed? Seriously injured? Sexually or physically assaulted?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
l) Have you ever been in any other situation where you were seriously injured or your life was in danger (e.g., involved in military combat or living in a war zone)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
m) Have you ever been in any other situation that was extremely frightening or horrifying, or one in which you felt extremely helpless, that you haven't reported?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

POSTTRAUMATIC STRESS DISORDER

Posttraumatic Symptom Scale (PTSS-10)

91. Below is a list of items about common reactions to serious events (e.g. death of a beloved person, violence, accidents etc). The items concern your feelings or reactions during the past week. (Please tick.)

	Yes ▼ ₁	No ▼ ₂
a) Have a hard time to sleep	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b) Have had nightmares	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c) Have been depressed (feeling blue)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d) Have had tendency to over-react to sudden noises or unexpected movements	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e) Have had tendency to withdraw from other people	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f) Have been irritable (easy to irritated or angry)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
g) Have had rapid changes in mood (swung between sadness and happiness)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
h) Have had bad conscience, self-accusations or feelings of guilt	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
j) Have been tense in the body	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
k) Have been afraid when remained about the event or when near the place where it occurred	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

Thank you very much; it was a pleasure interviewing you!

THANK YOU!

