

MAYO STUDY OF LYMPHOMA AND LEUKEMIA
3-YEAR FOLLOW-UP

1-7

Clinic Number: __ - __ - __ - __ - __ - __ - __ - __

INSTRUCTIONS: PLEASE CHECK THE APPROPRIATE BOX OR FILL IN THE BLANK AS INDICATED.

8-15

Today's Date: ___ ___ / ___ ___ / ___ ___ ___
Month Day Year

16_

1. What is your marital status?

- 1 Married or living as married 2 Widowed 3 Divorced or separated 4 Single, never married

17-24

2. What is your current employment status? (Mark all that apply.)

- 1 Employed full-time 1 Student 1 Homemaker 1 Disabled
 1 Employed part-time 1 Retired 1 Medical leave 1 Unemployed

HEALTH STATUS

25_

3. Would you say that your current health is:

- 1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

26-28

4. What is your current weight in pounds? ___ ___ ___ Pounds

IF YOU ARE MALE, PLEASE SKIP TO QUESTION 7 ON PAGE 2.

29_

5. A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?

- 1 No 2 Yes 3 Don't know/not sure

↓

In what year did you have your most recent mammogram?

___ ___ ___ ___ Year 1 Don't know/not sure

30-33

34_

35_

6. A clinical breast exam is when a doctor, nurse, or other health professional feels the breasts for lumps. Have you ever had a clinical breast exam?

1 No 2 Yes 3 Don't know/not sure

In what year did you have your most recent breast exam?

___ ___ ___ ___ Year 1 Don't know/not sure

36-39

40_

IF YOU ARE FEMALE, PLEASE SKIP TO QUESTION 8 BELOW.

41_

7. A prostate-specific antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. Have you ever had a PSA test?

1 No 2 Yes 3 Don't know/not sure

In what year did you have your most recent PSA test?

___ ___ ___ ___ Year 1 Don't know/not sure

42-45

46_

47_

8. A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. Have you ever had this test using a home kit?

1 No 2 Yes 3 Don't know/not sure

In what year did you have your most recent blood stool test using a home kit?

___ ___ ___ ___ Year 1 Don't know/not sure

48-51

52_

53_

9. Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had either of these exams?

1 No 2 Yes 3 Don't know/not sure

In what year did you have your most recent sigmoidoscopy or colonoscopy?

___ ___ ___ ___ Year 1 Don't know/not sure

54-57

58_

59_

10. Have you ever had an influenza vaccination (“flu shot” usually given in the fall to prevent getting the flu)?

- 1 No
- 2 Yes
- 3 Don’t know/not sure

↓

In what year did you have your most recent flu shot?

_ _ _ _ Year 1 Don’t know/not sure

60-63
64_

65_

11. Have you ever attended a cancer survivor group?

- 1 No
- 2 Yes

↓

What is the total number of meetings you have attended?

- 1 1
 - 2 2 to 5
 - 3 6 to 10
 - 4 11 or more

66_

67_

12. Have you ever seen a mental health professional (psychiatrist, psychologist, social worker, etc.) because of your lymphoma or leukemia?

- 1 No
- 2 Yes

↓

What is the total number of visits you have made to a mental health professional since you were diagnosed with lymphoma or leukemia?

- 1 1
 - 2 2 to 5
 - 3 6 to 10
 - 4 11 or more

68_

13. Below is a list of statements that other people with cancer have said are important. By checking one (1) number per line, please indicate how true each statement has been for you during the past 7 days.

Not at all A little bit Somewhat Quite a bit Very much


PHYSICAL WELL-BEING

69_ I have lack of energy. 1 2 3 4 5

70_ I have nausea. 1 2 3 4 5

71_ **Because of my physical condition, I have trouble meeting the needs of my family. 1 2 3 4 5**

72_ I have pain. 1 2 3 4 5

73_ I am bothered by side effects of treatment. 1 2 3 4 5

74_ **I feel ill. 1 2 3 4 5**

75_ I am forced to spend time in bed. 1 2 3 4 5

SOCIAL/FAMILY WELL-BEING

76_ I feel close to my friends. 1 2 3 4 5

77_ I get emotional support from my family. 1 2 3 4 5

78_ **I get support from my friends. 1 2 3 4 5**

79_ My family has accepted my illness. 1 2 3 4 5

80_ I am satisfied with family communication about my illness. 1 2 3 4 5

81_ **I feel close to my partner (or the person who is my main support). 1 2 3 4 5**

Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please check the box below and go to the emotional well-being section on page 5.

Not at all A little bit Somewhat Quite a bit Very much


82_ 0 I prefer not to answer it.

83_ I am satisfied with my sex life. 1 2 3 4 5

EMOTIONAL WELL-BEING

Not at all A little bit Somewhat Quite a bit Very much

- 84_ I feel sad. 1 2 3 4 5
- 85_ I am satisfied with how I am coping with my illness. 1 2 3 4 5
- 86_ I am losing hope in the fight against my illness. 1 2 3 4 5
- 87_ I feel nervous. 1 2 3 4 5
- 88_ I worry about dying. 1 2 3 4 5
- 89_ I worry that my condition will get worse. 1 2 3 4 5

FUNCTIONAL WELL-BEING

- 90_ I am able to work (include work at home). 1 2 3 4 5
- 91_ My work (include work at home) is fulfilling. 1 2 3 4 5
- 92_ I am able to enjoy life. 1 2 3 4 5
- 93_ I have accepted my illness. 1 2 3 4 5
- 94_ I am sleeping well. 1 2 3 4 5
- 95_ I am enjoying the things I usually do for fun. 1 2 3 4 5
- 96_ I am content with the quality of my life right now. 1 2 3 4 5

14. Please check the number (0 - 10) that best describes your feelings during the past week, including today. How would you describe:

Your overall quality of life?

- 97-98_ 0 1 2 3 4 5 6 7 8 9 10
- As bad as it can be As good as it can be

Your overall spiritual well-being?

- 99-100_ 0 1 2 3 4 5 6 7 8 9 10
- As bad as it can be As good as it can be

101_ 15. Have you ever used any tobacco products for six months or longer? (Please include cigarettes, cigars, pipes, snuff, and chewing tobacco.)

1 No → **Go to question 17 on page 7.**

2 Yes

Have you ever smoked cigarettes for six months or longer?

1 No 2 Yes

At what age did you start smoking cigarettes?

__ __ Age 1 Don't know

Do you smoke cigarettes now?

1 No

What year did you stop smoking cigarettes?

__ __ __ __ Year 1 Don't know

Before stopping, how many cigarettes did you usually smoke per day?

__ __ Cigarettes per day 1 Don't know

2 Yes

How many cigarettes do you usually smoke per day?

__ __ Cigarettes per day 1 Don't know

How has your smoking changed since your diagnosis of lymphoma or leukemia?

1 No change 2 Decreased 3 Increased

119_ 16. Do you currently use any of the other following tobacco products? (Mark all that apply.)

1 Cigar 2 Pipe 3 Snuff 4 Chewing tobacco

120_ 17. During your entire life, have you had 12 drinks or more of any kind of alcoholic drink? (One drink of alcohol is equal to one can of beer, one glass of wine, or one shot of liquor, e.g., whiskey, brandy, or gin.)

1 No 2 Yes

121_ **On average, how many drinks of alcohol do you usually have?**

- 1 Less than one each month
- 2 1 to 3 each month
- 3 1 to 2 each week
- 4 3 to 6 each week
- 5 1 to 2 each day
- 6 3 or more each day

122_ **How has your use of alcohol changed since your diagnosis of lymphoma or leukemia?**

- 1 No change 2 Decreased use 3 Increased use

PHYSICAL ACTIVITY

18. During a typical 7-day period (a week), how many times on the average do you do the following kinds of exercise for more than 15 minutes during your free time (write on each line the appropriate number).

123-124 a. **STRENUOUS EXERCISE (HEART BEATS RAPIDLY)** ___ ___ Times per week
(e.g. running, jogging, hockey, football, soccer, squash, basketball, cross country skiing, judo, roller skating, vigorous swimming, vigorous long-distance bicycling)

125-126 b. **MODERATE EXERCISE (NOT EXHAUSTING)** ___ ___ Times per week
(e.g. fast walking, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, popular and folk dancing)

127-128 c. **MILD EXERCISE (MINIMAL EFFORT)** ___ ___ Times per week
(e.g. yoga, archery, fishing from river bank, bowling horseshoes, golf, snowmobiling, easy walking)

129_ 19. During a typical 7-day period (a week), in your leisure time, how often do you engage in any regular activity long enough to work up a sweat (heart beats rapidly)?

1 Often 2 Sometimes 3 Never/rarely

130_ 20. How has your level of physical activity changed since your diagnosis of lymphoma or leukemia?

1 No change 2 Decreased level of activity 3 Increased level of activity

For questions 22 and 23, physical activity or exercise includes activities such as walking briskly, jogging, bicycling, swimming or any other activity where the exertion is at least as hard as these activities.

Your heart rate and breathing should increase.

No Yes

131_ 21. I am currently physically active. 0 1

132_ 22. I intend to become more physically active in the next months. 0 1

For questions 24 and 25, for activity to be regular, it must add up to a total of 30 minutes or more per day, and be done at least 5 days per week. For example, you could take one 30-minute walk, or take three 10-minute walks each day.

No Yes

133_ 23. I currently engage in regular physical activity. 0 1

134_ 24. I have been regularly physically active for the past 6 months. 0 1

DIET

25. Following are a few questions about your eating habits over the past month. (Mark only one response for each question.)

Never Rarely Sometimes Often Almost always Don't eat food(s)

135_ How often did you substitute low fat dairy produce for regular products? 1 2 3 4 5 6

136_ How often did you eat hamburgers, hot dogs, or luncheon meats? 1 2 3 4 5 6

137_ If you ate chicken, how often did you have it fried? 1 2 3 4 5 6

138_ How often did you eat at least 2 servings a day of vegetables like carrots, celery corn, peppers, broccoli, etc.? 1 2 3 4 5 6

139_ How often did you eat at least one serving of cereal a day? 1 2 3 4 5 6

Continued next page...

		Never	Rarely	Sometimes	Often	Almost always	Don't eat food(s)
140_	If you eat salads, how often did you use light, fat free, or no dressing?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
141_	How often did you reduce the amount of butter, margarine, or oil in a recipe to cut down on fat?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
142_	If you ate fish, how often did you have it fried?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
143_	How often did you have at least 1 serving of fruit a day?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
144_	When you include cheese on sandwiches or in cooking, how often did you substitute fat-reduced or low-fat cheese for regular cheese?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
145_	If you ate red meat, how often did you eat small portions to cut down on fat?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
146_	If you ate chicken, how often did you bake or broil it?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
147_	How often did you have fruit or vegetables as a snack?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
148_	How often did you substitute low fat foods for high fat foods?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
149_	How often did you eat tacos, hamburgers, and other fast foods?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
150_	If you ate fish, how often did you have it baked, broiled, or poached?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
151_	How often did you have at least 3 servings a week of broccoli, cabbage, or cauliflower?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
152_	If you use mayonnaise, how often did you use light, low fat, or fat free mayonnaise instead of regular?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
153_	How often did you avoid putting butter or margarine on your bread to cut down on fat?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
154_	How often did you pan fry foods?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
155_	How often did you eat bread, rolls, or muffins made from whole grains (whole wheat, rye, or pumpernickel)?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
156_	How often did you eat french fries?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
157_	How often did you eat dark bread?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

158_ 26. Do you believe that diet can change the course of lymphoma or leukemia?

1 2 3 4 5
 Not at all Very much

159_ 27. Have you modified your diet because you were diagnosed with lymphoma or leukemia?

1 2 3 4 5
 Not at all Very much

160_ 28. Have you modified your diet because you were concerned about health problems other than cancer?

1 2 3 4 5
 Not at all Very much

29. Since your diagnosis of lymphoma or leukemia, have you:

	No ▼	Yes ▼
161_ reduced fats?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
162_ increased fiber?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
163_ increased soy product?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
164_ increased tomatoes, tomato sauce?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
165_ decreased red meat?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
166_ increased vegetables from the cabbage family?	1 <input type="checkbox"/>	2 <input type="checkbox"/>
167_ tried to lose weight?	1 <input type="checkbox"/>	2 <input type="checkbox"/>

168_ 30. Have you taken multiple vitamins in the last year? (Please report other individual vitamins in question 31)

1 No - Go to question 31. 2 Yes

	Brand name (please list)	How often?				Change since diagnosis		
		1 to 3 times per wk.	4 to 6 times per wk.	Once every day	More than 7 per wk.	Less ▼	Same ▼	More
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
169-173	_____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
174-178	_____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
179-183	_____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
184-188	_____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

31. Not counting multiple vitamins, did you take any of the following vitamins or minerals in the last year?

	No		Yes		How often?				Change since diagnosis			Usual dose?
	1	2	1	2	1 to 3 times per week	4 to 6 times per week	Once every day	More than 7 per week	Less	Same	More	
189-192 Vitamin A (not beta carotene)	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	1 <input type="checkbox"/> 8,000 IU or less 2 <input type="checkbox"/> 8,500 IU or more
193-196 Beta carotene	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	1 <input type="checkbox"/> 8,000 IU or less 2 <input type="checkbox"/> 8,500 IU or more
197-200 Vitamin C	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	1 <input type="checkbox"/> 500 mg or less 2 <input type="checkbox"/> 550 mg or more
201-204 Vitamin E	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	1 <input type="checkbox"/> 400 mg or less 2 <input type="checkbox"/> 450 mg or more
205-208 Folic acid	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	1 <input type="checkbox"/> 400 µg or less 2 <input type="checkbox"/> 450 µg or more
209-212 Vitamin B6	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	1 <input type="checkbox"/> 10 mg or less 2 <input type="checkbox"/> 11 mg or more
213-216 Vitamin B12	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	1 <input type="checkbox"/> 10 µg or less 2 <input type="checkbox"/> 11 µg or more
217-219 Vitamin D	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
220-223 Calcium (include Tums)	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	1 <input type="checkbox"/> 700 mg or less 2 <input type="checkbox"/> 750 mg or more
224-227 Zinc	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	1 <input type="checkbox"/> 25 mg or less 2 <input type="checkbox"/> 30 mg or more
228-231 Selenium	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	1 <input type="checkbox"/> 50 µg or less 2 <input type="checkbox"/> 51 µg or more
232-234 Niacin	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
235-237 Iron	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
238-240 Magnesium	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	

Other Vitamins or Minerals (Please specify:)

241-250 _____	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____
251-260 _____	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____
261-270 _____	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____
271-280 _____	1 <input type="checkbox"/>	2 <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	_____

32. Have you ever tried any of the following herbal supplements? (Mark all that apply.)		Previously used		Currently using		
		Never used	For cancer	For other health issues	For cancer	For other health issues
281-285	a. Algae/spirulina	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
286-290	b. Aloe	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
291-295	c. Barley green	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
296-300	d. Bee pollen	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
301-305	e. Black walnut	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
306-310	f. Cat's claw - Uncaria tomentosa	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
311-315	g. Chinese herbs	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
316-320	h. Dandelion	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
321-325	i. DHEA	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
326-330	j. Echinacea	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
331-335	k. Essiac tea	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
336-340	l. Essiae	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
341-345	m. Evening primrose oil	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
346-350	n. Flaxseed	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
351-355	o. Garlic	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
356-360	p. Ginkgo	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
361-365	q. Ginseng	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
366-370	r. Grape seed extract	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
371-375	s. Green tea	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
376-380	t. Hawaiian herbs	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
381-385	u. Hawaiian salt	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
386-390	v. Herb mixtures, unspecified ..	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
391-395	w. Herbal tea	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>

Have you ever tried any of the following herbal supplements? (Mark all that apply.)		Previously used		Currently using	
		Never used	For cancer	For other health issues	For cancer
<u>Herbal supplement use</u>		▼	▼	▼	▼
396-400	x. Horse tail	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
401-405	y. Hoxey formula	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
406-410	z. Licorice root	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
411-415	aa. Marijuana	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
416-420	bb. Milk thistle	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
421-425	cc. Mistletoe	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
426-430	dd. Mushroom extract tea	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
431-435	ee. Noni	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
436-440	ff. Orange zest	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
441-445	gg. Parsley	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
446-450	hh. Pau d'arco	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
451-455	ii. Peppermint	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
456-460	jj. Red clover	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
461-465	kk. Royal jelly	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
466-470	ll. Saw palmetto	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
471-475	mm. Shark cartilage	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
476-480	nn. Shark liver	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
481-485	oo. St. John's Wort	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
486-490	pp. Wheat grass	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
491-495	qq. White fish supplement	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
496-500	rr. Yam	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>

33. Have you ever tried any of the following alternative therapies?
(Mark all that apply.)

		Previously used		Currently using	
		For cancer	For other health issues	For cancer	For other health issues
		Never used			
		▼			
<u>Mind/Body</u>					
501-505	Bioelectromagnetics	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
506-510	Meditation	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
511-515	Relaxation	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
516-520	Yoga	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
<u>Manual healing</u>					
521-525	Acupuncture	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
526-530	Chiropractic	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
531-535	Massages	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
436-540	Therapeutic touch	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
<u>Alternative medical</u> (Please specify:)					
541-545	_____ 1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
546-550	_____ 1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
551-555	_____ 1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
556-560	_____ 1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
<u>Traditional Chinese medicine</u> (Please specify:)					
561-565	_____ 1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
566-570	_____ 1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
571-575	_____ 1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
576-580	_____ 1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
<u>Religious/spiritual</u> (Please specify:)					
581-585	_____ 1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
586-590	_____ 1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
591-595	_____ 1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>

Have you ever tried any of the following alternative therapies? Check all that apply.

	Never used	Previously used		Currently using	
		For cancer	For other health issues	For cancer	For other health issues
<u>Naturopathy</u> (Please specify:)					
596-600	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
601-605	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
606-610	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
611-615	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
<u>Homeopathy</u> (Please specify:)					
616-620	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
621-625	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
626-630	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
631-635	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>

34. **Even if you have never used complementary/alternative medicine, answer this question.**
In your opinion, how true are the following statements about complementary/alternative products or therapies for cancer care?

	Not true at all	Not very true	Don't know	Fairly true	Very true
636_ They will cure the cancer.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
637_ They will prevent the spread of the cancer. ...	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
638_ They will assist other treatments to work.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
639_ They will relieve the symptoms.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
640_ They have side effects.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
641_ They weaken the body's natural reserves.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
642_ It is the patient's fault if they don't work.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
643_ They assist the body's natural forces to heal. ...	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
644_ It is easy to understand how they work.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
645_ They will provide a boost to the immune system.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

Continued next page...

		Not true at all	Not very true	Don't know	Fairly true	Very true
646_	They are perfectly safe.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
647_	They will increase the quality of life.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
648_	They give a feeling of control over the cancer.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
649_	They will prevent a recurrence of the cancer. ...	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
650_	They can reduce the chance that conventional medicine will work.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

35. Below are a series of statements cancer survivors have made to describe changes in their life after diagnosis. Please indicate your perspective by marking on a scale of 1 (Not at all) to 5 (Very much).

		Not at all				Very much
651_	Surviving cancer has changed my outlook on life.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
652_	I lead a healthier lifestyle.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
653_	Surviving cancer has forced me to deal with other issues in my life.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
654_	I no longer have time for unimportant activities; I'm more selective about what I do. .	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
655_	I get less worried about trivial things.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
656_	I am more particular about the people I become friends with.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
657_	I worry about the cancer coming back.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
658_	I think about my body more.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
659_	I feel more vulnerable now, as if the world is a more dangerous place.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
660_	I feel less comfortable with my body.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
661_	My body has let me down, I can no longer trust it in the same way.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

36. A number of statements which people have used to describe themselves are given below. Read each statement and then check the appropriate box to the right of the statement to indicate how you feel right now, that is, at this moment. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

		Not at all	Somewhat	Moderately so	Very much so
662_	a. I feel calm	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
663_	b. I feel secure	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
664_	c. I am tense	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
665_	d. I feel strained	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
666_	e. I feel at ease	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
667_	f. I feel upset	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
668_	g. I am presently worrying over possible misfortunes	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
669_	h. I feel satisfied	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
670_	i. I feel frightened	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
671_	j. I feel comfortable	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
672_	k. I feel self-confident	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
673_	l. I feel nervous	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
674_	m. I am jittery	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
675_	n. I feel indecisive	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
676_	o. I am relaxed	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
677_	p. I feel content	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
678_	q. I am worried	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
679_	r. I feel confused	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
680_	s. I feel steady	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
681_	t. I feel pleasant	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

37. A number of statements which people have used to describe themselves are given below. Read each statement and then check the appropriate box to the right of the statement to indicate how you generally feel.

		Almost never	Sometimes	Often	Almost always
682_	a. I feel pleasant	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
683_	b. I feel nervous and restless	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
684_	c. I feel satisfied with myself	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
685_	d. I wish I could be as happy as others seem to be	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
686_	e. I feel like a failure	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
687_	f. I feel rested	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
688_	g. I am "calm, cool, and collected"	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
689_	h. I feel that difficulties are piling up so that I cannot overcome them	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
690_	i. I worry too much over something that really doesn't matter	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
691_	j. I am happy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
692_	k. I have disturbing thoughts	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
693_	l. I lack self-confidence	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
694_	m. I feel secure	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
695_	n. I make decisions easily	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
696_	o. I feel inadequate	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
697_	p. I am content	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
698_	q. Some unimportant thought runs through my mind and bothers me	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
699_	r. I take disappointments so keenly that I can't put them out of my mind	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
700_	s. I am a steady person	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
701_	t. I get in a state of tension or turmoil as I think over my recent concerns and interests	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

38. Below is a list of words that describe feelings people have. Please read each one carefully. Then check one box under the answer to the right which best describes how you have been feeling during the past week including today.

		Not at all	A little	Moderately	Quite a bit	Extremely
702_	a. Tense	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
703_	b. Angry	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
704_	c. Worn out	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
705_	d. Lively	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
706_	e. Confused	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
707_	f. Shaky	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
708_	g. Sad	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
709_	h. Active	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
710_	i. Grouchy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
711_	j. Energetic	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
712_	k. Unworthy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
713_	l. Uneasy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
714_	m. Fatigued	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
715_	n. Annoyed	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
716_	o. Discouraged	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
717_	p. Nervous	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
718_	q. Lonely	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
719_	r. Muddled	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
720_	s. Exhausted	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
721_	t. Anxious	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
722_	u. Gloomy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
723_	v. Sluggish	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
724_	w. Weary	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
725_	x. Bewildered	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
726_	y. Furious	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
727_	z. Efficient	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
728_	aa. Full of pep	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
729_	bb. Bad-tempered	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
730_	cc. Forgetful	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
731_	dd. Vigorous	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

39. We welcome any comments you may wish to provide.

732_

Thank you for taking the time to participate in this survey!

Question 13: © US English 1987, 1997, David Cella, Ph.D., Fact-G (Version 4).

Question 18 and 19: © Godin, G. and Shephard, R. J., A Simple Method to Assess Exercise Behavior in the Community. Can. J. Appl. Spt. Sci. 10:3 141-146, 1985.

Questions 21 to 24: ©Marcus, B. H., Rossi, J. S., Selby, V. C., Niaura, R. S., & Abrams, D. B. (1992). The stages and processes of exercise adoption and maintenance in a worksite sample. Health Psychology, 11, 386-395.

Question 34: Complementary/Alternative Medicine Survey developed by Boon et al, 2004.

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