

Services and resources questionnaire

(Adapted from Client Service Receipt Inventory, Beecham and Knapp, 2001)

Please tell us about your **health care**

Hospital

In the last **3 months** have you been to hospital?

	No/Yes		Number of times in last 3 months	Reason why you went to hospital
Accident and emergency (A&E)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Number of visits:	Reason: 1 st time:..... 2 nd time:..... 3 rd time:..... 4 th time:.....
Stayed in hospital overnight	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Number of nights: 1 st stay:..... 2 nd stay:..... 3 rd stay:..... 4 th stay:.....	Reason: 1 st :..... 2 nd :..... 3 rd :..... 4 th :.....
Hospital daytime appointment	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Number of appointments:	Reason: 1 st time:..... 2 nd time:..... 3 rd time:..... 4 th time:.....

Residential or nursing home

In the last **3 months** have you

Lived in a residential home ?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	How many nights?	Privately funded? No <input type="checkbox"/> Yes <input type="checkbox"/>
Lived in a nursing home ?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	How many nights?	Privately funded? No <input type="checkbox"/> Yes <input type="checkbox"/>

ID letters	ID numbers	Date	RA initials

Community services

In the **last three months** how often have you seen:

Community NHS health services	How often in last 3 months?	At home?
GP		No <input type="checkbox"/> Yes <input type="checkbox"/>
Practice nurse		No <input type="checkbox"/> Yes <input type="checkbox"/>
District nurse		No <input type="checkbox"/> Yes <input type="checkbox"/>
Speech and Language therapist		No <input type="checkbox"/> Yes <input type="checkbox"/>
Occupational therapist		No <input type="checkbox"/> Yes <input type="checkbox"/>
Physio therapist		No <input type="checkbox"/> Yes <input type="checkbox"/>
Psychologist		No <input type="checkbox"/> Yes <input type="checkbox"/>
Counsellor		No <input type="checkbox"/> Yes <input type="checkbox"/>
Other community health professional: please describe		No <input type="checkbox"/> Yes <input type="checkbox"/>
Social services	How often in last 3 months?	
Social worker		
Home help/ carer		
Meals on wheels		
Social services day care centre		
Other services	How often in last 3 months?	
Stroke or aphasia group		
Volunteer visited you		
Other community groups (e.g. lunch club)		
Other: please describe		

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Private therapists

Have you **paid** to see a private therapist in the **last 3 months**? Yes No

Private Services	Number of times paid to see therapist in last 3 months
Speech and Language Therapist	
Physiotherapist	
Counsellor	
Psychologist	
Other therapist: please describe	

Medication

Please list the drugs you are taking currently

Name of drug	Dosage (if known)	Dosage frequency	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Are you taking antidepressants? Yes No

Over the last 3 months have you paid for any of your prescriptions? Yes No

If yes, **how much** have you paid for your prescriptions in the **last 3 months**?

£

Help from **family and friends** because of your stroke or other illness

In the **last 3 months** help from **family or friends**:

Help received (because of stroke or other illness)	No/Yes	Typically, how many hours a week?
Personal care (e.g. help with washing or dressing)	No <input type="checkbox"/> Yes <input type="checkbox"/>	Hours each week:
Preparing meals	No <input type="checkbox"/> Yes <input type="checkbox"/>	Hours each week:
Housework (e.g. laundry)	No <input type="checkbox"/> Yes <input type="checkbox"/>	Hours each week:
Providing transport (e.g. giving you lifts)	No <input type="checkbox"/> Yes <input type="checkbox"/>	Hours each week:
Shopping	No <input type="checkbox"/> Yes <input type="checkbox"/>	Hours each week:
Taking you for outings	No <input type="checkbox"/> Yes <input type="checkbox"/>	Hours each week:
Other types of support: please describe		Hours each week:

In the last 3 months have family or friends **stayed off work** to help you?

No Yes If yes, how many days?

Employment

Are you now:

Working full-time	No <input type="checkbox"/> Yes <input type="checkbox"/>
Working part-time work	No <input type="checkbox"/> Yes <input type="checkbox"/>
Volunteer	No <input type="checkbox"/> Yes <input type="checkbox"/>
Student	No <input type="checkbox"/> Yes <input type="checkbox"/>
Retired	No <input type="checkbox"/> Yes <input type="checkbox"/>
Home maker/ caring for others	No <input type="checkbox"/> Yes <input type="checkbox"/>
Unable to work (health reasons)	No <input type="checkbox"/> Yes <input type="checkbox"/>
Unemployed and looking for work	No <input type="checkbox"/> Yes <input type="checkbox"/>

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About this form

How long did this form take to complete?

Under 5 minutes	5-10 minutes	10-20 minutes	More than 20 minutes

How easy was this form to complete?

Very Easy	Quite Easy	Neither easy nor difficult	Quite Difficult	Very Difficult

Comments:.....

Who completed this form?

I did	I did with help from family	I did with help from a researcher	Someone in my family filled it in on my behalf

Date you completed it: _ _ / _ _ / _ _ _ _
 d d / m m / y y y y

Thank you for completing this form!

Please return to:

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