Penn State ALS Clinic Caregiver Assessment - Initial V.8.19.2010

1. Welcome

Welcome to the Hershey ALS Clinic Caregiver Assessment. We want to get to know you so that we can provide you with the support that you need. Please take some time to complete the caregiver assessment. This will be reviewed with you in confidence at your upcoming ALS clinic appointment. We will ask you to complete this assessment approximately every 3 months.

Thank you very much!

The ALS Clinic Team

Date

Date of your upcoming ALS Clinic appointment: MM ___ / DD ___ / YYYY ___

Please provide us with your contact information.

Your Name:

Name of ALS Patient:

Email Address:

Phone Number:

Please tell us your age in years.

Age

Gender

- Male
- Female

Ethnicity

- Caucasian - Not Hispanic
- African American
- Hispanic
- Asian
- Prefer not to answer

Other (please specify)

What is your relationship to the patient with ALS?

- Spouse
- Significant other
- Sibling
- Parent
- Child
- Friend

Other (please specify)

What is your living arrangement in relation to the patient with ALS?

- I live with them
- I live somewhere else

Other (please specify)

What is your employment status?

- Full-time employment
- Part-time employment
- Retired
- On Disability

Other (please specify)

Quality of Life

	Very bad										Excellent
Considering all parts of my life - physical, emotional, social, spiritual, and financial - over the past week, the quality of my life hase been:											

Penn State Hershey ALS Clinic Caregiver Assessment - Initial V.8.19.2010

2. Caregiving Tasks

Please tell us about your level of concern (e.g., worry, anxiety, unease) with providing the care activities listed below.

If you do not provide the care activity, please record this by marking "I do not provide this activity" on the far right of the response options.

	1 Low Concern				5 High Concern	I do not provide this activity
Feeding						
Bathing/Grooming						
Dressing						
Help with communicating						
Help with toileting						
Mobility (help with transfers, walking, steps, body positioning, etc)						
Exercises to improve strength, maintain range of motion, including stretching						
Assistance with medication (administrating medications and/or management of medications)						
Help with equipment and devices						
Offer emotional support and/or spiritual support						
Encourage loved one to participate in different activities						
Encourage prevention of injuries or accidents						
Coordinating care with other family members/friends/professional caregivers						
Work with health insurance and available programs (i.e., OVR, VA)						
Meal preparation/Housekeeping						
Shopping/community involvement						
Financial management						

Please describe other activities that you do.

Caregiving Hours

How many hours per day are you the actual caregiver to the person with ALS?

Help in the home

	Yes	No
Would additional help in the home be useful for you?		

3. Caregiver Supports

What activities do you engage in that are supportive to you? Please check all that apply.

- Exercise
- Prayer ,meditation, or connecting with a community of faith
- Socializing with friends and family
- Art/music
- Spending time with animals
- Journaling
- Reading
- Hobby
- Working
- Volunteering
- Attending educational sessions about ALS
- Counseling
- Support Group
- None
- I do not know what support I need.

Other, please specify.

What activities are you no longer doing that you enjoyed previously?

What is preventing you from participating in supportive activities?

4. Caregiver Health and Well-Being

Are you being followed by a family doctor?

- Yes
- No

Does your family doctor know that you are a primary caregiver?

- Yes
- No

Health Assessment

	1 Very healthy	2	3	4	5	6	7	8	9	10 Very ill
On a scale of 1 to 10 with 1 being “very healthy” to 10 being “very ill”, please rate your current health compared to what it was this time last year.										

Stress Assessment

	1 Not Stressful	2	3	4	5	6	7	8	9	10 Extremely Stressful
On a scale of 1 to 10, with 1 being “not stressful” to 10 being “extremely stressful”, please rate how stressful your life is.										

Over the past two weeks, I have felt down, depressed, or hopeless

- True
- False

If true, have you felt this way for:

- several days
- more than 1/2 the days
- nearly every day

Over the past two weeks, I have felt little interest or pleasure in doing things

- True
- False

If true, have you felt this way for

- several days
- more than 1/2 the days
- nearly every day

5. Caregiver Confidence

.

	1 Very Low	2	3 Moderate	4	5 Very High
What is your perception of your ability to do what needs to be done?					
What is your level of comfort with your problem solving ability?					

What qualities and personal strengths do you bring to your caring role?

What is the most rewarding thing for you about caring for your loved one?

What are your primary concerns about caregiving?

Is there anything else that you would like to share with us?