

BMS Adult Interview Form II: Research Staff Instructions

Instructions: This form is designed to aid in the interview process. If you are handing the form to the participant for them to fill out, use the mail version of this form instead. Instructions to the interviewer appear throughout the survey in italics, and scripts to read aloud to the participants appear using quotation marks. The scripts to read aloud are also boxed and shaded in light gray. Use these scripts as suggestions for how to move through the survey while establishing rapport with the participant.

Missing codes appear throughout this interview in small boxes. If a participant doesn't want to answer any item or doesn't know the answer, circle "88" (Declined to Answer/Refused) or "99" (Unknown) in that item's corresponding missing code box. Some items have missing codes built into their response options and therefore don't have those code boxes.

Remember to fill out the Medical Record Abstraction Form II. For the pain medication items, check the medical record to determine if there were any pain medications prescribed within the data collection window. Note on the Medical Record Abstraction Form II form and enter in the appropriate field during data entry.

Form II Administration:	
Follow-up period <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> 1. 6-month follow-up <input type="checkbox"/> 2. 12 month follow-up <input type="checkbox"/> 3. 24 month follow-up <input type="checkbox"/> 4. 5 year follow-up </div> <div style="width: 50%;"> <input type="checkbox"/> 5. 10 year follow-up <input type="checkbox"/> 6. 15 year follow-up <input type="checkbox"/> 7. 20 year follow-up <input type="checkbox"/> 8. 25 year follow-up </div> </div>	
What is the method of administration of this form? <input type="checkbox"/> 2. Mail <input type="checkbox"/> 5. Medical Record Review	What is the language of administration of this form? <input type="checkbox"/> 1. English <input type="checkbox"/> 2. Spanish
What is the status of this follow-up assessment? <input type="checkbox"/> 1. Some or all assessment done <input type="checkbox"/> 2. Death due to burn related complications (update date and cause of death on Patient Status Form) <input type="checkbox"/> 3. Death due to non-burn related complications (update date and cause of death on Patient Status Form) <input type="checkbox"/> 4. Unable to locate <input type="checkbox"/> 5. Refused this assessment <input type="checkbox"/> 6. Unable to test/med comp/incapable of responding <input type="checkbox"/> 7. Failed to respond <input type="checkbox"/> 8. Did not consent to future assessment/withdrew <input type="checkbox"/> 11. Incarcerated <input type="checkbox"/> 13. Still in hospital (not discharged yet) <input type="checkbox"/> 14. Unable to travel for assessment <input type="checkbox"/> 15. Death (unknown causes) (update date and cause of death on Patient Status Form)	
If follow-up status is "unable to locate," mark the best reason, below: <input type="checkbox"/> 1. Homeless at previous data collection <input type="checkbox"/> 2. International place of residence <input type="checkbox"/> 3. Participant is child who was/is in CPS custody or foster care and no contact information is available <input type="checkbox"/> 4. No known current contact info <input type="checkbox"/> 5. Other reasons <input type="checkbox"/> 6. Unable to contact due to Shriners Hospital regulations	

Burn Model System Follow-up Survey

Introduction Script (replace this script with your personalized center introduction script if applicable or modify as needed to facilitate the flow and rapport of the interview):

“Hi my name is _____ and I am calling from _____ to ask you some questions about how you have been doing (since your injury)... or (since we last spoke with you on (last follow-up date)). Thank you for continuing to participate in our study. The aim of the study is to learn about how people do after a burn injury. Your answers will help us understand the experiences of all people with burn injury and I appreciate your willingness to share those experiences. I’ll be asking questions about your burn injury, your health, and other questions about you and people around you. I will guide you as we go along. You may notice that some questions are similar and feel repetitive. This is not a mistake and is part of the research process. All information will be kept confidential.

If you are unsure how to answer a question, please give the answer that fits you best. You can choose to skip any questions you don’t want to answer or feel uncomfortable answering. Just tell me, “skip.” Please let me know at any time if you have any questions.”

Today's Date: ____ / ____ / ____

“As a reminder, your last research study questionnaire was completed on ____/____/____.”

“We’re going to go ahead and get started.”

Section I

1. What is your primary mode of transportation?

- ☐ 1. Driving my own vehicle
- ☐ 2. Riding with someone else
- ☐ 3. Public transit
- ☐ 4. Not applicable (I don’t use motorized transport)

88/Refused

99/Unknown


2. Since your last research study questionnaire, have you spoken with other burn survivors to get support for problems related to your burn injury?

- ☐ 1. Yes
- ☐ 2. No
- ☐ 99. I don’t know

88/Refused

3. To your knowledge, in the last year have you had COVID-19?

Or, if this is a 6 month interview, say, Since your last research study questionnaire, have you had COVID-19?

- ☐ 1. Yes 
- ☐ 2. No
- ☐ 99. I don't know

88/Refused

(If yes), What month and year did you have COVID-19?
(if you've had COVID-19 more than once, provide the month and year of your first illness)

Month: _____

Year: _____

88/Refused

99/Unknown

What level of care did you receive for COVID-19?

- ☐ 1. Did not seek medical care
- ☐ 2. Received medical care but was not hospitalized
- ☐ 3. Was hospitalized
- ☐ 88. Refused
- ☐ 99. Unknown

In the hospital... (if applicable)

- ☐ 1. I was NOT on a ventilator (breathing machine with tube down your throat)
- ☐ 2. I was on a ventilator
- ☐ 3. I don't know

88/Refused

4. Since your last research study questionnaire, have you received any of the following services at home or outpatient? (Choose all that apply)


- ☐ 1. No services
- ☐ 2. Occupational therapy
- ☐ 3. Physical therapy
- ☐ 4. Speech language pathology
- ☐ 5. Social work
- ☐ 6. Psychological services
- ☐ 7. Vocational services
- ☐ 99. I don't know

If clarification is needed, say "Examples of occupational therapy include helping with adaptive equipment and work environment after an injury. Examples of physical therapy include range of motion and walking exercises."

88/Refused

Interviewer instructions: If the participant didn't receive any services OR if they didn't receive PT/OT, skip to #9 on page 4

5. If yes to OT and/or PT, How many sessions of occupational and/or physical therapy have you had in the past 4 weeks? (If you don't know exactly, use your best guess)

- ☐ 1. One
- ☐ 2. 2 to 4
- ☐ 3. 5 to 10
- ☐ 4. More than 10
- ☐ 77. Not applicable (no OT/PT received)  skip to #9 on page 4
- ☐ 99. I don't know

88/Refused

If yes to OT and/or PT, Since your last research study questionnaire, <u>where</u> did you receive your outpatient occupational or physical burn therapy?	
6. At the burn center? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 77. Not applicable (no OT/PT received) <input type="checkbox"/> 99. I don't know	<div style="border: 1px solid black; padding: 2px; display: inline-block;">88/Refused</div>
7. At any other facility? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 77. Not applicable (no OT/PT received) <input type="checkbox"/> 99. I don't know	<div style="border: 1px solid black; padding: 2px; display: inline-block;">88/Refused</div>
8. Using telehealth? (for example, meeting with your therapist using video conferencing) <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 77. Not applicable (no OT/PT received) <input type="checkbox"/> 99. I don't know	<div style="border: 1px solid black; padding: 2px; display: inline-block;">88/Refused</div>
9. Since your last research study questionnaire, have you had any burn related surgeries (such as surgeries for open wounds or scar management)? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know <div style="text-align: right; margin-top: 10px;"> <div style="border: 1px solid black; padding: 2px; display: inline-block;">88/Refused</div> </div>	<div style="margin-bottom: 10px;"> <i>(If the participant <u>did</u> have burn related surgeries) Have you had any burn-related surgeries outside of this clinical center?</i> </div> <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 99. I don't know <div style="text-align: right; margin-top: 10px;"> <div style="border: 1px solid black; padding: 2px; display: inline-block;">88/Refused</div> </div>

Section 2				
Please answer each question as it relates to your <u>current</u> health				
Do you currently have:				
1. Hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
2. Change in voice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
3. Vision problems not corrected by glasses or contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
4. Eyelid problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
5. Excessive tearing of the eyes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
6. Difficulty with memory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
7. Difficulty with thought processing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused
8. Numbness, pins and needles or burning sensations in your burn scar?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Refused

9. Numbness, pins and needles or burning sensations in your hands?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
10. Numbness, pins and needles or burning sensations in your feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
11. Trouble with your balance?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
12. Varicose veins?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
13. Swollen feet or legs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
14. Swollen hands or arms?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
15. Difficulty breathing when doing your regular daily activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
16. Skin cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
17. Joint pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
18. Have you been pregnant or fathered a child since your last research study questionnaire?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
19. Blood clots in legs or lungs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
20. Cold intolerance?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
21. Excessive sweating?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
22. Difficulty in hot environments?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused
23. Is your skin more sensitive than before your burn?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused

Section 3

1. Are you **currently** taking prescription medication for pain on a regular basis?

- ☐ 1. Yes
☐ 2. No
☐ 99. I don't know

88/Refused

2. Are you **currently** taking prescription medication for itch on a regular basis?

- ☐ 1. Yes
☐ 2. No
☐ 99. I don't know

88/Refused

3. In the **past 12 months**, did you take medication for being, worried, tense, or anxious?

- ☐ 1. Yes
☐ 2. No
☐ 99. I don't know

88/Refused

4. In the past 12 months, did you take medication for being sad, empty, or depressed?

- ☐ 1. Yes
☐ 2. No
☐ 99. I don't know

88/Refused

5. Since your last research study questionnaire, have you received psychological therapy or counseling due to your burn injury?

88/Refused

- ☐ 1. Yes
☐ 2. No
☐ 99. I don't know


Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.

Section 4

Please respond to each question or statement by marking one box per row

In the past 7 days...

How intense was your itch in general?.....

- ☐ 0=0 No itch 
☐ 1=1
☐ 2=2
☐ 3=3
☐ 4=4
☐ 5=5
☐ 6=6
☐ 7=7
☐ 8=8
☐ 9=9
☐ 10=10 Worst imaginable itch

If the participant did not have any itch in the past 7 days, skip to Section 5 on page 7.

If they did have itch in the past 7 days, continue on with the rest of Section 4

Please respond to each question or statement by marking one box per row

In the past 7 days...	Never	Rarely	Sometimes	Often	Almost Always
because of itch, it was hard to work.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
because of itch, it was hard to do even simple tasks.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
because of itch, I made more mistakes than normal.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
because of itch, it was hard to watch television.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Please respond to each question or statement by marking one box per row					
In the past 7 days...	Never	Rarely	Sometimes	Often	Almost Always
because of itch, I felt miserable.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
because of itch, I felt sad.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
because of itch, I was restless.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
because of itch, I had difficulty falling asleep....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.

Section 5					
Please respond to each question or statement by marking one box per row.					
	Excellent	Very good	Good	Fair	Poor
In general, would you say your health is:...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In general, would you say your quality of life is:.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In general, how would you rate your physical health?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In general, how would you rate your mental health, including your mood and your ability to think?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In general, how would you rate your satisfaction with your social activities and relationships?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Completely	Mostly	Moderately	A little	Not at all
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past 7 days...	Never	Rarely	Sometimes	Often	Always
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past 7 days...	None	Mild	Moderate	Severe	Very Severe
How would you rate your fatigue on average?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.

Section 6					
Please respond to each question or statement by marking one box per row.					
<u>Physical Function</u>	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to do chores such as vacuuming or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to go up and down stairs at a normal pace?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to go for a walk of at least 15 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to run errands and shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Anxiety</u>	Never	Rarely	Sometimes	Often	Always
In the past 7 days...					
I felt fearful.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I found it hard to focus on anything other than my anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My worries overwhelmed me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt uneasy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>Depression</u> In the past 7 days...	Never	Rarely	Sometimes	Often	Always
I felt worthless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt helpless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt depressed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt hopeless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Fatigue</u> During the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
I feel fatigued.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have trouble <u>starting</u> things because I am tired.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
How run down did you feel on average?...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How fatigued were you on average?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Sleep Disturbance</u> In the past 7 days...	Very poor	Poor	Fair	Good	Very good
My sleep quality was.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was refreshing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I had a problem with my sleep.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I had difficulty falling asleep.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Ability to Participate in Social Roles and Activities</u>	Never	Rarely	Sometimes	Usually	Always
I have trouble doing all of my leisure activities with others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have trouble doing all of the family activities that I want to do.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have trouble doing all of my usual work (include work at home).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have trouble doing all of the activities with friends that I want to do.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pain Interference In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
How much did pain interfere with your day to day activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much did pain interfere with work around the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much did pain interfere with your ability to participate in social activities? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much did pain interfere with your household chores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pain Intensity In the past 7 days...										
How would you rate your pain on average?...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4	5	6	7	8	9 10
	No pain								Worst pain imaginable	

“In order to understand if and how a burn injury changes people’s satisfaction with their sex life, we ask a few questions about sexual function. Everybody can answer these questions. If you did not have any sexual activity in the past 30 days, please rate how satisfied you are with no sexual activity.”

Please respond to each item by marking one box per row.

In the past 30 days...	Not at all	A little bit	Somewhat	Quite a bit	Very
How satisfied have you been with your sex life?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past 30 days...	None	A little bit	Somewhat	Quite a bit	Very much
How much pleasure has your sex life given you?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Interviewer Instructions: If the participant **had a hand burn**, please complete the next 4 questions. If they **did NOT have a hand burn**, please move on to Section 7 on the next page.

Please respond to each item by marking one box per row.

Upper Extremity	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to cut your food using utensils?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to open a can with a hand can opener?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to button your shirt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to pick up coins from a table top?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.

Section 7

Please respond to each question or statement by marking one box per row.

Lately...	Never	Rarely	Sometimes	Often	Always
1. Because of my injury, some people avoided me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Because of my injury, I felt left out of things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Because of my injury, people avoided looking at me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I felt embarrassed about my injury.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Because of my injury, some people seemed uncomfortable with me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I felt embarrassed because of my physical limitations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Because of my injury, people were unkind to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Some people acted as though it was my fault I have this injury.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 8 *Interviewer instructions: Write in 88 for refused or 99 for unknown for this section***Please answer thinking of your burn wounds/scars RIGHT NOW**

How bothered are you about...	Not at all	A little	Quite a bit	A lot
...how your wounds/scars look when they are not covered up (for example without clothes or makeup)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...how noticeable your wounds/scars are to other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...how your wounds/scars look overall?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 9

This section asks about alcohol use in the past year (*Or, since your last research study questionnaire, if your burn was less than a year ago*).

If the participant says they did not drink alcohol in the past year, **mark this box ☐** and then skip to Section 10, below

In the past year...(*Or, since your last research study questionnaire, if the burn was less than a year ago*).

1. Have you felt you needed to cut down on your drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No	88/Refused 99/Unknown
2. Have people annoyed you by criticizing your drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No	88/Refused 99/Unknown
3. Have you ever felt guilty about drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No	88/Refused 99/Unknown
4. Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover?	<input type="checkbox"/> Yes <input type="checkbox"/> No	88/Refused 99/Unknown

Section 10

This section asks about drug use in the past year (*Or, since your last research study questionnaire, if your burn was less than a year ago*).

If the participant says they did not use drugs in the past year, **mark this box ☐** and then skip to Section 11 on the next page

The questions in this section are asking about use of drugs like crack or heroin; or about prescription drugs like pain killers or stimulants that were not prescribed to you; or chemicals you might have inhaled or 'huffed'. We also want to know if sometimes you took more than you should have of any drugs that have been prescribed to you.

In the past year...(*Or, since your last research study questionnaire, if the burn was less than a year ago*)

1. Have you felt you needed to cut down on your drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	88/Refused 99/Unknown
2. Have people annoyed you by criticizing your drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	88/Refused 99/Unknown
3. Have you ever felt guilty about your drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	88/Refused 99/Unknown
4. Have you ever felt you needed to use drugs first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover?	<input type="checkbox"/> Yes <input type="checkbox"/> No	88/Refused 99/Unknown

Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.

Section II					
Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then mark circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.					
In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Section 12	
Currently:	
1. Who usually looks after your personal finances, such as banking and paying bills? <input type="checkbox"/> 1. Yourself alone <input type="checkbox"/> 2. Yourself and someone else <input type="checkbox"/> 3. Someone else	<div>88/Refused</div> <div>99/Unknown</div>
Approximately how many times a month do you usually participate in the following activities outside of your home?	
2. Shopping <input type="checkbox"/> 1. Never <input type="checkbox"/> 2. One to four times <input type="checkbox"/> 3. 5 or more times	<div>88/Refused</div> <div>99/Unknown</div>
3. Leisure activities such as movies, sports, and restaurants. <input type="checkbox"/> 1. Never <input type="checkbox"/> 2. One to four times <input type="checkbox"/> 3. 5 or more times	<div>88/Refused</div> <div>99/Unknown</div>
4. Visiting friends or relatives <input type="checkbox"/> 1. Never <input type="checkbox"/> 2. One to four times <input type="checkbox"/> 3. 5 or more times	<div>88/Refused</div> <div>99/Unknown</div>
5. When you participate in leisure activities do you usually do this alone or with others? <input type="checkbox"/> 1. Mostly alone <input type="checkbox"/> 2. Mostly with friends who have burn injuries <input type="checkbox"/> 3. Mostly with family members <input type="checkbox"/> 4. Mostly with friends who do not have burn injuries <input type="checkbox"/> 5. With a combination of family and friends <input type="checkbox"/> 77. Not applicable (no leisure activities)	<div>88/Refused</div> <div>99/Unknown</div>
6. Do you have a best friend with whom you confide? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 88. Refused <input type="checkbox"/> 99. I don't know	

Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.

Section 13							
Here are 4 statements with which you may agree or disagree. Using a scale where 1 represents you strongly disagree and 7 represents that you strongly agree, indicate your agreement with each item by the appropriate choice Please be open and honest in your response.							
	Strongly disagree =1	Disagree =2	Slightly disagree =3	Neither agree nor disagree =4	Slightly agree =5	Agree =6	Strongly agree =7
1. In most ways my life is close to ideal:	<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
2. The conditions of my life are excellent:	<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
3. I am satisfied with my life:	<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
4. So far, I have gotten the important things I want in life:	<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

Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.

Section 14						
These are some questions about ways people sometimes change after difficult events. Indicate for each of the next statements the degree to which this change occurred in your life as a result of your burn injury, using these response categories: 0 = I did not experience this change as a result of my burn injury 1 = I experienced this change to a very small degree as a result of my burn injury 2 = I experienced this change to a small degree as a result of my burn injury 3 = I experienced this change to a moderate degree as a result of my burn injury 4 = I experienced this change to a great degree as a result of my burn injury 5 = I experienced this change to a very great degree as a result of my burn injury						
	I did not experience this change	To a very small degree	To a small degree	To a moderate degree	To a great degree	To a very great degree
1. I changed my priorities about what is important in life.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. I have a greater appreciation for the value of my own life.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. I am able to do better things with my life.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. I have a better understanding of spiritual matters.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. I have a greater sense of closeness with others.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

	I did not experience this change	To a very small degree	To a small degree	To a moderate degree	To a great degree	To a very great degree
6. I established a new path for my life.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7. I know better that I can handle difficulties.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. I have a stronger religious faith.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9. I've discovered that I'm stronger than I thought I was.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. I learned a great deal about how wonderful people are.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Interviewer instructions: Write in 88 for refused or 99 for unknown for this section.

Section 15					
Please respond to all questions. Please mark one box per row.					
Please rate how well each statement describes you right now.	Not at all	A little bit	Somewhat	Quite a bit	Very much
1. I maintain a positive outlook even in bad circumstances.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When something happens that makes me feel stressed, I usually calm down quickly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When something stressful happens, I keep going.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. When things go wrong in my life, I can pick myself up and start again.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 16		
This is the last section of the survey		
1. What is your current weight? (lbs) _____	<input type="checkbox"/> I don't know	88/Refused
2. What is your current height? (feet/inches) _____	<input type="checkbox"/> I don't know	88/Refused
3. Where are you currently living? (Choose only one)		88/Refused
<input type="checkbox"/> 1. Private residence <input type="checkbox"/> 2. Nursing home <input type="checkbox"/> 3. Adult home <input type="checkbox"/> 4. Correctional institution <input type="checkbox"/> 5. Hotel/motel <input type="checkbox"/> 6. Homeless <input type="checkbox"/> 7. Hospital		99/Unknown
4. What is your current zip code? ____-____-____ <input type="checkbox"/> Not applicable (not living in U.S.) <input type="checkbox"/> Not applicable (homeless) (code 99999 for unknown)		
5. Who are you currently living with? (Choose all that apply)		88/Refused
<input type="checkbox"/> 1. Alone <input type="checkbox"/> 2. Spouse/partner/significant other <input type="checkbox"/> 3. Friend <input type="checkbox"/> 4. Parent or step-parent <input type="checkbox"/> 5. Other relative (siblings, grandparents) <input type="checkbox"/> 6. Others, not part of family <input type="checkbox"/> 7. Guardian <input type="checkbox"/> 8. Young children <input type="checkbox"/> 9. Adult children <input type="checkbox"/> 99. I don't know		
6. What is your current marital status? (Choose only one)		88/Refused
<input type="checkbox"/> 1. Married; living common-law or with a partner <input type="checkbox"/> 2. Separated <input type="checkbox"/> 3. Divorced <input type="checkbox"/> 4. Widowed <input type="checkbox"/> 5. Single (not married)		99/Unknown
<i>If clarification is needed, say, "The following question asks about your income. We appreciate this information because income is often related to health. For instance, we'd like to know if families with lower reported income have more trouble accessing health care, such as dental care or physical therapy. Having this information helps us advocate for better programs that serve people with burn injuries."</i>		

7. Approximately what was your family's total income for the last full year (total income of all family members living with you in your household)? (in U.S. dollars)		<div style="border: 1px solid black; padding: 2px;">99/Unknown</div>
<input type="checkbox"/> 1. Less than \$25,000 <input type="checkbox"/> 2. \$25,000-\$49,999 <input type="checkbox"/> 3. \$50,000-\$99,999 <input type="checkbox"/> 4. \$100,000-\$149,999 <input type="checkbox"/> 5. \$150,000-\$199,999 <input type="checkbox"/> 6. \$200,000 or more <input type="checkbox"/> 7. Living outside the United States <input type="checkbox"/> 77. Not applicable (e.g., living in an institution) <input type="checkbox"/> 88. Prefer not to answer		
8. How many people are in your household? _____		<div style="border: 1px solid black; padding: 2px;">88/Refused</div> <div style="border: 1px solid black; padding: 2px;">99/Unknown</div>
9. In the past year, how many months did you work for pay? _____ (fill in # of months) <input type="checkbox"/> Don't know		<div style="border: 1px solid black; padding: 2px;">88/Refused</div>
10. What is your primary occupation (or what was your primary occupation the last time you worked, if the answer to the above was less than 1 month)? <u>Occupation:</u> _____ (not name of company)		<div style="border: 1px solid black; padding: 2px;">88/Refused</div> <div style="border: 1px solid black; padding: 2px;">99/Unknown</div>
<u>Occupation Categories [for staff use only]</u> 1 - Executive, Administrative, And Managerial, 2 - Professional Specialty, 3 - Technicians And Related Support, 4 - Sales, 5 - Administrative Support Including Clerical, 6 - Private Household, 7 - Protective Service, 8 - Service, Except Protective And Household, 9 - Farming, Forestry, And Fishing, 10 - Precision Production, Craft, And Repair, 11 - Machine Operators, Assemblers, And Inspectors, 12 - Transportation And Material Moving, 13 - Handlers, Equipment Cleaners, Helpers, And Laborers, 14 - Military Occupations		
11. What is your current employment status? (Choose only one) <input type="checkbox"/> 1. Working → <input type="checkbox"/> 2. Not working (looking for work) <input type="checkbox"/> 3. Not working (<u>not</u> looking for work) <input type="checkbox"/> 4. Homemaker/caregiver <input type="checkbox"/> 5. Volunteer <input type="checkbox"/> 6. Retired	<div style="border: 1px solid black; padding: 5px;"> (If the participant was working) About how many <u>hours a week</u> do you work for pay? <div style="border: 1px solid black; padding: 2px; width: 100%;"> <div style="border: 1px solid black; padding: 2px;">88/Refused</div> <div style="border: 1px solid black; padding: 2px;">99/Unknown</div> </div> _____ (fill in # of hours) </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> If the participant hadn't already returned to work/school before their last research study questionnaire but they are working now, What was your first date to return to work/school since your injury? (Please take your best guess if you don't know the exact date): ____ / ____ / ____ </div>	
<div style="border: 1px solid black; padding: 2px;">88/Refused</div> <div style="border: 1px solid black; padding: 2px;">99/Unknown</div>		

Interviewer Instructions: If the participant is not currently working, skip to #14, below.

12. (If you are currently working,) Have you received any work accommodations from your employer due to your burn injury? This could include a change in procedure or schedule, a modification to your work site, or assistive equipment.

- ☐ 1. No, my employer was not asked for accommodations and I did not receive any
- ☐ 2. No, my employer was asked for accommodations, but the request was denied
- ☐ 3. Yes, my employer was asked for accommodations and I received some or all accommodations asked for
- ☐ 4. Yes, my employer provided accommodations without being asked.
- ☐ 99. I don't know

88/Refused

99/Unknown

Interviewer Instructions: Skip #13 and move on to #14 if the participant declined to answer the household income question or if the participant is a one-person household (fill in income from household question if the participant is a one-person household).

13. Approximately what was your individual income for the past full year? (in U.S. dollars)

- ☐ 1. Less than \$25,000
- ☐ 2. \$25,000-\$40,999
- ☐ 3. \$41,000-\$55,999
- ☐ 4. \$56,000-\$70,999
- ☐ 5. \$71,000-\$85,999
- ☐ 6. \$86,000-\$100,000
- ☐ 7. Greater than \$100,000
- ☐ 8. Living outside the United States
- ☐ 77. Not applicable (no individual income)
- ☐ 88. Prefer not to answer

99/Unknown

14. What is your current school status?

- ☐ 1. In school
- ☐ 2. Not in school

If you are not working or going to school, why not?

- ☐ Not applicable (working or going to school)
- ☐ Burn related
- ☐ Other medical problems
- ☐ Problems with employer
- ☐ Emotional/social reasons
- ☐ Legal reasons/jail
- ☐ Substance abuse
- ☐ Personal choice
- ☐ Other
- ☐ Retired
- ☐ Homemaker/caregiver
- ☐ Unemployed but actively seeking employment
- ☐ I don't know

88/Refused

88/Refused

99/Unknown

15. How many years of education have you completed?

(If you have not graduated from high school, please indicate the number of years spent in school. If you have at least a high school diploma, please indicate the highest degree earned or worked toward post-high school. In other words, what is the highest level of education you have completed?)

- ☐ 1. 1 year or less
- ☐ 2. 2 years
- ☐ 3. 3 years
- ☐ 4. 4 years
- ☐ 5. 5 years
- ☐ 6. 6 years
- ☐ 7. 7 years
- ☐ 8. 8 years
- ☐ 9. 9 years
- ☐ 10. 10 years
- ☐ 11. 11 or 12 years; no diploma
- ☐ 12. High school diploma or equivalent (ie, GED)
- ☐ 13. Work towards Associate's degree, vocational degree, or trade school diploma/cert.
- ☐ 14. Associate's degree, vocational degree, or trade school diploma/certificate
- ☐ 15. Work towards Bachelor's degree
- ☐ 16. Bachelor's degree
- ☐ 17. Work towards Master's degree
- ☐ 18. Master's degree
- ☐ 19. Work towards doctorate level degree
- ☐ 20. Doctoral level degree
- ☐ 66. Other

88/Refused

99/Unknown

16. Are you currently receiving disability income such as Social Security Disability or Private Long Term Insurance disability? (Choose all that apply)

- ☐ 1. I am not receiving disability income
- ☐ 2. Social Security Disability
- ☐ 3. Private long term insurance disability income
- ☐ 4. Supplemental security income (SSI)
- ☐ 5. Worker's compensation
- ☐ 6. Other (please specify) _____
- ☐ 99. I don't know

If yes, are you receiving disability income due to your burn injury?

- ☐ 1. Yes, I am receiving disability income due to my burn injury
- ☐ 2. No, I am not receiving disability income due to my burn injury
- ☐ 77. Not applicable (not receiving disability income)
- ☐ 99. I don't know

88/Refused

88/Refused

17. Do you currently have any physical problems, such as a mobility impairment (difficulty moving your arms, legs or body)?

- ☐ 1. Yes
- ☐ 2. No
- ☐ 99. I don't know

88/Refused

18. Who is the primary sponsor of your care currently, or who is paying for the majority of your burn care costs? (Choose only one)

- ☐ 1. Medicare
- ☐ 2. Medicaid (DSHS)
- ☐ 3. Private insurance/HMO/PPO/Pre-paid/Managed
- ☐ 4. Worker's compensation (L&I)
- ☐ 6. Champus/Tri-Care
- ☐ 7. Self-pay or indigent (public support)
- ☐ 9. VA
- ☐ 10. Other
- ☐ 11. Philanthropy (private support or private foundation or Shriners hospital)
- ☐ 77. Not applicable (no burn care costs)
- ☐ 99. I don't know

☐ 88/Refused

19. Have you ever served in the military?

- ☐ 1. No
- ☐ 2. Yes

☐ 88/Refused☐ 99/Unknown

Length of interview: _____

"Is there anything else you would like to tell us? _____

"Thank you very much for sharing your experiences with us!"