

## BMS Adult Mail Form I: Research Staff Instructions

**Instructions:** The first page should be filled out by research staff and then separated from the mail form before sending or giving to the participant. Fill in contact information at the end of the Introduction for participant in case of questions before sending out mail form or before handing to participant.

After receiving the completed form in the mail or from a participant, go through the survey over carefully to see if the participant missed any questions. If possible, call the participant or ask them in person the questions that were missed. If a participant doesn't want to answer any item or doesn't know the answer and there isn't a box/option for those responses on that item, write: "88" (Decline to Answer/Refused) or "99" (Don't know/Unknown) next to the item.

<b>Form I Administration:</b>		
<b>What is the method of administration of this form?</b> <input type="checkbox"/> 2. Mail <input type="checkbox"/> 5. Medical Record Review	<b>What is the language of administration of this form?</b> <input type="checkbox"/> 1. English <input type="checkbox"/> 2. Spanish	<b>Checklist of forms:</b> <b>Mark when each is complete</b> <input type="checkbox"/> 1. Patient Status Form <input type="checkbox"/> 2. Medical Record Abstraction Form <input type="checkbox"/> 3. Form I

## **Burn Model System Hospital Discharge Survey: Introduction**

Thank you for agreeing to participate in this 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. Some questions ask about what things were like before your burn injury, other questions are about your health now. 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. Some questions have instructions to help you answer them better. These instructions appear in italics.

**Please answer all questions and be as accurate as possible. If you have any questions please contact us at: \_\_\_\_\_.**

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<b>Section I</b>			
<b>Please answer each question as it relates to your <u>current</u> health</b>			
<b>Do you currently have:</b>			
1. Hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
2. Change in voice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
3. Vision problems not corrected by glasses or contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
4. Eyelid problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
5. Excessive tearing of the eyes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
6. Difficulty with memory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
7. Difficulty with thought processing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
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
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
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
11. Trouble with your balance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
12. Varicose veins?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
13. Swollen feet or legs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
14. Swollen hands or arms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
15. Skin cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
16. Joint pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
17. Have you ever been pregnant or fathered a child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
18. Blood clots in legs or lungs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
19. Cold intolerance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
20. Excessive sweating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
21. Difficulty in hot environments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know

## Pre-Injury History Section

Please answer these questions about your situation before the injury. Your answers will help us understand problems related to the injury. All information will be kept confidential. Please answer all questions and be as accurate as possible.

<b>Section 2</b>							
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 as it was 4 weeks prior to your burn. 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 the 4 weeks before my burn, in most ways my life was close to ideal:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the 4 weeks before my burn, the conditions of my life were excellent:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In the 4 weeks before my burn, I was satisfied with my life:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In the 4 weeks before my burn, I had gotten the important things I wanted in life:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Section 3****During the 4 weeks before your burn:**

1. Who usually looked after your personal finances, such as banking and paying bills?

- ☐ 1. Yourself alone
- ☐ 2. Yourself and someone else
- ☐ 3. Someone else

**Approximately how many times during the 4 weeks before the burn did you participate in the following activities outside of your home?**

2. Shopping

- ☐ 1. Never
- ☐ 2. 1-4 times
- ☐ 3. 5 or more times

3. Leisure activities such as movies, sports, and restaurants.

- ☐ 1. Never
- ☐ 2. 1-4 times
- ☐ 3. 5 or more times

4. Visiting friends or relatives

- ☐ 1. Never
- ☐ 2. 1-4 times
- ☐ 3. 5 or more times

**During the 4 weeks before your burn:**

5. When you participated in leisure activities did you usually do this alone or with others?

- ☐ 1. Mostly alone
- ☐ 3. Mostly with family members
- ☐ 4. Mostly with friends
- ☐ 5. With a combination of family and friends
- ☐ 77. Not applicable (no leisure activities)

6. Did you have a best friend with whom you confided?

- ☐ 1. Yes
- ☐ 2. No

Section 4												
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 before your burn was...	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
In general, would you say your quality of life before your burn was...	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
In general, how would you rate your physical health before your burn?...	<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, before your burn?...	<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 before your burn?...	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
In general, please rate how well you carried out your usual social activities and roles before your burn. (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 were you able to carry out your everyday physical activities before your burn, 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"/>			
<b>In the 4 weeks before your burn...</b>	Never		Rarely		Some-times		Often		Always			
How often were you 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"/>			
<b>In the 4 weeks before your burn...</b>	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"/>			
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"/>	<input type="checkbox"/>	
	0	1	2	3	4	5	6	7	8	9	10	
	No Pain										Worst pain imaginable	

**Section 5**

1. In the month before your burn injury did you take prescription medication for pain on a regular basis?

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

**In the past 12 months...**

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

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

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

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

4. Did you receive psychological therapy or counseling in the last 12 months?

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

**Section 6**

1. Before your burn injury, where were you living? (Choose only one)

- ☐ 1. Private residence  
☐ 2. Nursing home  
☐ 3. Adult home  
☐ 4. Correctional institution  
☐ 5. Hotel/motel  
☐ 6. Homeless  
☐ 7. Hospital

2. What was your zip code at the time of your burn injury? \_\_\_\_ \_

- ☐ Not applicable (not living in U.S.)      ☐ Not applicable (homeless)

3. Who were you living with before your burn injury? (Choose all that apply)

- ☐ 1. Alone  
☐ 2. Spouse/partner/significant other  
☐ 3. Friend  
☐ 4. Parent or step-parent  
☐ 5. Other relative (siblings, grandparents)  
☐ 6. Others, not part of family  
☐ 7. Guardian  
☐ 8. Young children  
☐ 9. Adult children  
☐ 99. I don't know

4. What was your marital status at the time of your burn injury? (Choose only one)

- ☐ 1. Married; living common-law or with a partner  
☐ 2. Separated  
☐ 3. Divorced  
☐ 4. Widowed  
☐ 5. Single (not married)

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.

5. Approximately what was your family's total income in the last full year before your burn injury (total income of all family members living with you in your household)? (in U.S. dollars)

- ☐ 1. Less than \$25,000  
☐ 2. \$25,000-\$49,999  
☐ 3. \$50,000-\$99,999  
☐ 4. \$100,000-\$149,999  
☐ 5. \$150,000-\$199,999  
☐ 6. \$200,000 or more  
☐ 7. Living outside the United States  
☐ 77. Not applicable (e.g., living in an institution)  
☐ 88. Prefer not to answer

6. How many people are in your household? \_\_\_\_\_

7. In the year prior to your burn injury, how many months did you work for pay? \_\_\_\_\_  
☐ I don't know (fill in # of months)

8. Before your burn (or the last time you worked, if the answer to the above was less than 1 month), what was your primary occupation?

Occupation: \_\_\_\_\_ (not name of company)

Occupation Categories [for staff use only]

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

9. What was your employment status at the time of your burn? (Choose only one)

- ☐ 1. Working
- ☐ 2. Not working (looking for work)
- ☐ 3. Not working (not looking for work)
- ☐ 4. Homemaker/caregiver
- ☐ 5. Volunteer
- ☐ 6. Retired

*(If you were working) Before your burn, about how many hours a week did you work for pay?*

\_\_\_\_\_ *(fill in # of hours)*

10. Approximately what was your individual income in the last full year before your burn injury? (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

11. Were you going to school at the time of your burn injury?

- ☐ 1. In school
- ☐ 2. Not in school

*If you were not working or going to school at the time of your burn injury, why not?*

- ☐ Not applicable (working or going to school)
- ☐ 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

12. Before your burn injury, did you 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



13. Before your burn injury, were you ever told by a doctor that you had any of the following psychological issues (choose all that apply)?

- ☐ 0. None/no psychological issues  
☐ 1. Depression  
☐ 2. Bipolar disorder  
☐ 3. Anxiety  
☐ 4. Post-Traumatic Stress Disorder (PTSD)  
☐ 5. Schizophrenia/psychotic disorder  
☐ 6. Other, please explain: \_\_\_\_\_  
☐ 99. I don't know

## Section 7

*This section asks about alcohol use in the past year.*

*If you did not drink alcohol in the past year, **mark this box** ☐ and then skip to Section 8 below*

In the past year...

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Have you felt you needed to cut down on your drinking?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have people annoyed you by criticizing your drinking?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you ever felt guilty about drinking?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 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 |

## Section 8

*This section asks about drug use in the past year.*

*If you did not use drugs in the past year, **mark this box** ☐ and then skip to Section 9 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...

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Have you felt you needed to cut down on your drug use?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have people annoyed you by criticizing your drug use?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you ever felt guilty about your drug use?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 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 |

## Post-Injury History Section


All the questions you just answered were about the time before your burn injury. Next are some similar questions, but they are about the time since your burn injury. As a reminder, some of these questions can feel repetitive but it's part of the research process. Thank you for your patience.

<b>Section 9</b>											
In the past 7 days, or since your burn if you were injured less than 7 days ago...											
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"/>	<input type="checkbox"/>
	0	1	2	3	4	5	6	7	8	9	10
	<b>No pain</b>								<b>Worst pain imaginable</b>		

<b>Section 10</b>					
<b>Please respond to each question or statement by marking one box per row</b>					
In the past 7 days, or since your burn if you were injured less than 7 days ago...	<b>Not at all</b>	<b>A little bit</b>	<b>Some- what</b>	<b>Quite a bit</b>	<b>Very much</b>
How difficult was it for you to take in new information because of pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much did pain interfere with your enjoyment of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much did pain make it difficult to fall asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Never</b>	<b>Rarely</b>	<b>Some- times</b>	<b>Often</b>	<b>Always</b>
How often was pain distressing to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often was your pain so severe you could think of nothing else?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often did pain make you feel anxious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Section 11****In the past 7 days, or since your burn if you were burned less than 7 days ago...**

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 you did not have any itch in the past 7 days, or since your burn if you were burned less than 7 days ago, skip to Section 12 on page 12.*

*If you did have itch in the past 7 days, or since your burn if you were burned less than 7 days ago, continue on with the rest of Section 11, below.*

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

<b>In the past 7 days or since your burn if you were burned less than 7 days ago ...</b>	<b>Never</b>	<b>Rarely</b>	<b>Some-times</b>	<b>Often</b>	<b>Almost Always</b>
because of itch, it was hard to work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
because of itch, it was hard to do even simple tasks.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
because of itch, I made more mistakes than normal.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
because of itch, it was hard to watch television.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>In the past 7 days or since your burn if you were burned less than 7 days ago ...</b>	<b>Never</b>	<b>Rarely</b>	<b>Some-times</b>	<b>Often</b>	<b>Almost Always</b>
because of itch, I felt miserable.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
because of itch, I felt sad.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
because of itch, I was restless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
because of itch, I had difficulty falling asleep....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Section 12**

1. Are you of Hispanic, Latino, or Spanish Origin?

- ☐ 1. Yes, Hispanic, Latino, or Spanish origin
- ☐ 2. No, not of Hispanic, Latino, or Spanish origin
- ☐ 88. Prefer not to answer

2. What is your race?

- ☐ 1. African-American or Black
- ☐ 2. Asian
- ☐ 3. White
- ☐ 4. American Indian/Alaskan Native
- ☐ 5. Native Hawaiian or Other Pacific Islander
- ☐ 6. More than one race (please specify): \_\_\_\_\_
- ☐ 7. Some other race (please specify): \_\_\_\_\_
- ☐ 88. Prefer not to answer

**Section 13**

This is the last section of the survey.

1. After your hospital discharge, where are/will you be living? (Choose only one)

- ☐ 1. Private residence
- ☐ 2. Nursing home
- ☐ 3. Adult home
- ☐ 4. Correctional institution
- ☐ 5. Hotel/motel
- ☐ 6. Homeless
- ☐ 7. Hospital
- ☐ 99. I don't know

2. Who will you be living with after hospital discharge? (Choose all that apply)

- ☐ 1. Alone
- ☐ 2. Spouse/partner/significant other
- ☐ 3. Friend
- ☐ 4. Parent or step-parent
- ☐ 5. Other relative (siblings, grandparents)
- ☐ 6. Others, not part of family
- ☐ 7. Guardian
- ☐ 8. Young children
- ☐ 9. Adult children
- ☐ 99. I don't know

**3. 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

**4. 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

**5. Have you ever served in the military?**

- ☐ 1. No
- ☐ 2. Yes

How long did this survey take you to complete? \_\_\_\_\_

Is there anything else you would like to tell us? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Thank you very much for sharing your experiences with us.