

## Self-evaluation:

To Determine the Score:

1. Reverse score questions 5 and 15. (For example, a “No” response should be counted as “Yes” and a “Yes” response should be counted as “No”)
2. Total the number of “yes” responses.

## To Interpret the Score:

Chances are that you are experiencing a high degree of distress:

- If you answered “Yes” to either or both Questions 4 and 11; or
- If your total “Yes” score = 10 or more; or
- If your score on Question 17 is 6 or higher; or
- If your score on Question 18 is 6 or higher.

## Next steps:

- Consider seeing a doctor for a check-up for yourself.
- Consider having some relief from caregiving. (Discuss with the doctor or a social worker the resources available in your community.)
- Consider joining a support group

## Valuable Resources for Caregivers:

Eldercare Locator:  
(a national directory of community services)  
1-800- 677-1116  
[www.aoa.gov/elderpage/locator.html](http://www.aoa.gov/elderpage/locator.html)

Family Caregiver Alliance  
1-415- 434-3388  
[www.caregiver.org](http://www.caregiver.org)

Medicaid Hotline  
Baltimore, MD  
1-800-638-6833

National Alliance for Caregiving  
1-301-718-8444  
[www.caregiving.org](http://www.caregiving.org)

National Family Caregivers Association  
1-800 896-3650  
[www.nfcares.org](http://www.nfcares.org)

National Information Center for Children and Youth with Disabilities  
1-800-695-0285  
[www.nichcy.org](http://www.nichcy.org)

American Medical Association

Physicians dedicated to the health of America



# Caregiver Self-Assessment Questionnaire

How are you?

# Caregiver Self-Assessment Questionnaire

## How are you?

Caregivers are often so concerned with caring for their relative's needs that they lose sight of their own wellbeing. Please take just a moment to answer the following questions. Once you have answered the questions, turn the page to do a self-evaluation.

### During the past week or so, I have...

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- |   |   |
|---|---|
| 1. Had trouble keeping my mind on what I was doing ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         | 14. Felt ill ( <i>headaches, stomach problems or common cold</i> ) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                 |
| 2. Felt that I couldn't leave my relative alone..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             | 15. Been satisfied with the support my family has given me ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 3. Had difficulty making decisions ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 16. Found my relative's living situation to be inconvenient or a barrier to care ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   |
| 4. Felt completely overwhelmed..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 17. On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful," please rate your current level of stress. _____                        |
| 5. Felt useful and needed ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 18. 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. _____ |
| 6. Felt lonely ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | Comments:<br><i>(Please feel free to comment or provide feedback)</i>   |
| 7. Been upset that my relative has changed so much from his/her former self..... <input type="checkbox"/> Yes <input type="checkbox"/> No | _____   |
| 8. Felt a loss of privacy and/or personal time ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             | _____   |
| 9. Been edgy or irritable ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____   |
| 10. Had sleep disturbed because of caring for my relative ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                  | _____   |
| 11. Had a crying spell(s) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____   |
| 12. Felt strained between work and family responsibilities..... <input type="checkbox"/> Yes <input type="checkbox"/> No                  | _____   |
| 13. Had back pain ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | _____   |