

SELF-CARE INVENTORY

All answers are confidential.

Think about how you have been feeling in the last month as you complete this survey.

SECTION A:

Listed below are common self-care behaviors that people may do. How often or routinely do you do the following?

	Never		Sometimes		Always
1. Make sure to get enough sleep?	1	2	3	4	5
2. Try to avoid getting sick (e.g., flu shot, wash your hands)?	1	2	3	4	5
3. Do physical activity (e.g., take a brisk walk, use the stairs)?	1	2	3	4	5
4. Eat a balanced and varied diet?	1	2	3	4	5
5. See your healthcare provider for routine health care (e.g. routine check ups, dentist, gynecologist)?	1	2	3	4	5
6. If/when prescribed, take prescribed medicines without missing a dose?	1	2	3	4	5
7. Do something to relieve stress (e.g., meditation, yoga, music)?	1	2	3	4	5
8. Do you avoid tobacco smoke?	1	2	3	4	5

SECTION B:

Listed below are common things that people monitor. How often or routinely do you do the following?

	Never		Sometimes		Always
9. Monitor your health status?	1	2	3	4	5
10. If/when prescribed, monitor for medicine side-effects?	1	2	3	4	5
11. Pay attention to changes in how you feel?	1	2	3	4	5
12. Monitor whether you tire more than usual doing normal activities?	1	2	3	4	5

13. Monitor for symptoms?	1	2	3	4	5
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14. Think about the last time you had a symptom. This can be a symptom of anything – a cold, a bad night sleep, an illness. It could also be a reaction to a medicine.

(circle **one** number)

	I did not recognize the symptom	Not Quickly	Somewhat Quickly	Very Quickly		
How quickly did you recognize it as a symptom of an illness, health problem or medicine side effect?	0	1	2	3	4	5

SECTION C:

Listed below are behaviors that people use to control their symptoms. **When you have symptoms, how likely are you to use one of these?**

(circle **one** number for each behavior)

	Not Likely	Somewhat Likely	Very Likely		
15. Change what you eat or drink to make the symptom decrease or go away?	1	2	3	4	5
16. Change your activity level (e.g. slow down, rest)?	1	2	3	4	5
17. Take a medicine to make the symptom decrease or go away?	1	2	3	4	5
18. Tell your healthcare provider about the symptom at the next office visit?	1	2	3	4	5
19. Call your healthcare provider for guidance?	1	2	3	4	5

Think of things you did the last time you had a symptom...

(circle **one** number)

	I did not do anything	Not Sure	Somewhat Sure	Very Sure		
20. Did the things you did make you feel better?	0	1	2	3	4	5

SECTION D: SELF-CARE SELF-EFFICACY SCALE

In general, how confident are you that you can:

(Circle **one** number for each statement)

	Not Confident		Somewhat Confident		Very Confident
21. Keep yourself <u>stable and free of symptoms</u> ?	1	2	3	4	5
22. Follow the plan if you have been given a treatment?	1	2	3	4	5
23. <u>Persist</u> in following the plan if you have been given a treatment even when difficult?	1	2	3	4	5
24. <u>Monitor your health status</u> routinely?	1	2	3	4	5
25. <u>Persist</u> in routinely monitoring your health status even when difficult?	1	2	3	4	5
26. <u>Recognize changes</u> in your health if they occur?	1	2	3	4	5
27. <u>Evaluate the importance</u> of your symptoms?	1	2	3	4	5
28. <u>Do something</u> to relieve your symptoms?	1	2	3	4	5
29. <u>Persist</u> in finding a remedy for your symptoms even when difficult?	1	2	3	4	5
30. <u>Evaluate</u> how well a remedy works?	1	2	3	4	5

THANK YOU FOR COMPLETING THIS SURVEY!