**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 |
| 1. Try to avoid getting sick (e.g., flu shot, wash your hands)?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Do physical activity (e.g., take a brisk walk, use the stairs)?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Eat a balanced and varied diet?
 | 1 | 2 | 3 | 4 | 5 |
| 1. See your healthcare provider for routine health care (e.g. routine check ups, dentist, gynecologist)?
 | 1 | 2 | 3 | 4 | 5 |
| 1. If/when prescribed, take prescribed medicines without missing a dose?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Do something to relieve stress (e.g., meditation, yoga, music)?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Do you avoid tobacco smoke (both active and passive smoking)?
 | 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  |
| 1. Monitor your health status?
 | 1 | 2 | 3 | 4 | 5 |
| 1. If/when prescribed, monitor for medicine side-effects?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Pay attention to changes in how you feel?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Monitor whether you tire more than usual doing normal activities?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Monitor for symptoms?
 | 1 | 2 | 3 | 4 | 5 |

##### 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** |
| 1. Change what you eat or drink to make the symptom decrease or go away?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Change your activity level (e.g. slow down, rest)?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Take a medicine to make the symptom decrease or go away?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Tell your healthcare provider about the symptom at the next office visit?
 | 1 | 2 | 3 | 4 | 5 |
| 1. 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** |
| 1. Did the things you did make you feel better?
 | 0 | 1 | 2 | 3 | 4 | 5 |

THANK YOU FOR COMPLETING THIS SURVEY!

**SELF-CARE SELF-EFFICACY SCALE**

*All answers are confidential.*

In general, how confident are you that you can or could:

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not Confident** |  | **Somewhat Confident** |  | **Very Confident** |
| 1. Keep yourself stable and free of symptoms?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Follow the plan if you have been given a treatment?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Persist in following the plan if you have been given a treatment even when difficult?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Monitor your health status routinely?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Persist in routinely monitoring your health status even when difficult?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Recognize changes in your health if they occur?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Evaluate the importance of your symptoms?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Do something to relieve your symptoms?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Persist in finding a remedy for your symptoms even when difficult?
 | 1 | 2 | 3 | 4 | 5 |
| 1. Evaluate how well a remedy works?
 | 1 | 2 | 3 | 4 | 5 |

THANK YOU FOR COMPLETING THIS SURVEY!