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 (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
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

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13. Monitor for symptoms?	1	2	3	4	5

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

THANK YOU FOR COMPLETING THIS SURVEY!

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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				**Very Confident**
1. Keep yourself stable and free of symptoms?	1	2	3	4	5
2. Follow the plan if you have been given a treatment?	1	2	3	4	5
3. Persist in following the plan if you have been given a treatment even when difficult?	1	2	3	4	5
4. Monitor your health status routinely?	1	2	3	4	5
5. Persist in routinely monitoring your health status even when difficult?	1	2	3	4	5
6. Recognize changes in your health if they occur?	1	2	3	4	5
7. Evaluate the importance of your symptoms?	1	2	3	4	5
8. Do something to relieve your symptoms?	1	2	3	4	5
9. Persist in finding a remedy for your symptoms even when difficult?	1	2	3	4	5
10. Evaluate how well a remedy works?	1	2	3	4	5

THANK YOU FOR COMPLETING THIS SURVEY!

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