

## Health Psychology Department

The purpose of this questionnaire is to assess your perception of your health and well-being. There are no right or wrong answers. You will have an opportunity to discuss concerns or results later. If possible, please fill out a form for each caregiver you have shared information with. Please use black or blue ink.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex of Subject: \_\_\_\_\_ Gender: \_\_\_\_\_  
Living Alone: \_\_\_\_\_ Family/Relationship: \_\_\_\_\_

How do you usually yourself usually identify? (Please check all that apply)

- |                                                                  |                                                     |
|------------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> African American/Black                  | <input type="checkbox"/> South Asian                |
| <input type="checkbox"/> American Indian/Alaska Native           | <input type="checkbox"/> Middle Eastern             |
| <input type="checkbox"/> White/Caucasian/Anglo-American/Hispanic | <input type="checkbox"/> Native American            |
| <input type="checkbox"/> Asian/Pacific Islander                  | <input type="checkbox"/> French or French Canadian  |
| <input type="checkbox"/> Hispanic/Latino/Hispanic                | <input type="checkbox"/> Other (please list): _____ |

### Depression Status

How depressed do you feel most of the time? Yes No

If you have depression or anxiety or another illness how does your caregiver respond. (Please respond)

How does your medical complication when you receive an injection with you? Yes No

If you please explain

Did your doctor use any of the following during the procedure?

- Yes No
- Epidural/Spinal Block
- Other drugs

### Open-Ended

What was your best? What did you like? What did you not like? How long did you last last?

---

---

---

---

---