

Caregivers: Please complete this form **upon registration** into the Respite Program provided by funds from the Lifespan Respite Grant your Provider received

1. What was your **YEAR OF BIRTH**: \_\_\_\_\_

2. What is your **MARITAL STATUS**: (circle one)

- Married     Single     Widowed     Separated     Divorced

3. What is your **HIGHEST LEVEL OF EDUCATION?**

- Some High School     High School Graduate     Some College  
 Trade School     College Graduate     Graduate School

4. What is your **SEX**: (circle one)  Male     Female

5. What is your total yearly **INCOME**, including wages, Social Security, dividends, annuities, etc :

- Under \$5,000     \$5,000 to \$9,999     \$10,000 to \$14,999  
 \$15,000 to \$19,999     \$20,000 to \$24,999     \$25,000 to \$29,999  
 \$30,000 to \$34,999     \$35,000 to \$39,999     \$40,000 to \$44,999  
 Over \$45,000

6. What is your **RACE** (check all that apply):

- Black/African American     White/Caucasian     American Indian/Alaskan Native  
 Asian/Asian-American     Hawaiian/Pacific Islander     Other: \_\_\_\_\_

7. What is your relationship to the Care Recipient (e.g., I am their mother, daughter, friend, guardian, etc.)? \_\_\_\_\_

8. What is the age of the Care Recipient? \_\_\_\_\_

9. What is the primary reason for caring for the Care Recipient? \_\_\_\_\_

9. Approximately how long have you been a Caregiver to the Care Recipient? \_\_\_\_\_

Please circle yes or no to the following questions:

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

1. Had trouble keeping my mind on what I was doing	Yes	No
2. Felt that I couldn't leave my relative/care recipient alone	Yes	No
3. Had difficulty making my own decisions	Yes	No
4. Felt completely overwhelmed	Yes	No
5. Felt useful and needed	Yes	No
6. Felt lonely	Yes	No
7. Been upset that my relative/care recipient has changed so much from their former self	Yes	No
8. Felt a loss of privacy and/or personal time	Yes	No
9. Been edgy or irritable	Yes	No
10. Had crying spells	Yes	No
11. Had sleep disturbed because of caring for my relative/care recipient	Yes	No
12. Felt strained between work and family responsibilities	Yes	No
13. Had back pain	Yes	No
14. Felt ill	Yes	No
15. Been satisfied with the support my family/friends have given me	Yes	No
16. Found my relative/care recipient's living situation to be inconvenient or barrier to caregiving	Yes	No

PROVIDER ID \_\_\_\_\_

CLIENT ID \_\_\_\_\_

Caregivers: Please complete this form **at the conclusion** of the Respite Program provided by funds from the Lifespan Respite Grant your Provider received

1. How satisfied were you with the respite services you recently received?

Not at all     Slightly     Somewhat     Very     Extremely

2. If given the opportunity, would you apply for respite services again?  Yes  No

3. Did your respite provider talk with you about what kinds of activities you wanted to do during your respite time and help you plan for using that time?  Yes  No

4. If yes, how much do you agree with the following statement: I used my respite plan to do something I enjoyed and felt that the respite was "time well spent"?

Completely Disagree     Disagree a little     Unsure     Agree a little     Completely Agree

**Please circle yes or no to the following questions:**

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

<b>1. Had trouble keeping my mind on what I was doing</b>	<b>Yes</b>	<b>No</b>
<b>2. Felt that I couldn't leave my relative/care recipient alone</b>	<b>Yes</b>	<b>No</b>
<b>3. Had difficulty making my own decisions</b>	<b>Yes</b>	<b>No</b>
<b>4. Felt completely overwhelmed</b>	<b>Yes</b>	<b>No</b>
<b>5. Felt useful and needed</b>	<b>Yes</b>	<b>No</b>
<b>6. Felt lonely</b>	<b>Yes</b>	<b>No</b>
<b>7. Been upset that my relative/care recipient has changed so much from their former self</b>	<b>Yes</b>	<b>No</b>
<b>8. Felt a loss of privacy and/or personal time</b>	<b>Yes</b>	<b>No</b>
<b>9. Been edgy or irritable</b>	<b>Yes</b>	<b>No</b>
<b>10. Had crying spells</b>	<b>Yes</b>	<b>No</b>
<b>11. Had sleep disturbed because of caring for my relative/care recipient</b>	<b>Yes</b>	<b>No</b>

PROVIDER ID \_\_\_\_\_

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<b>12. Felt strained between work and family responsibilities</b>	<b>Yes</b>	<b>No</b>
<b>13. Had back pain</b>	<b>Yes</b>	<b>No</b>
<b>14. Felt ill</b>	<b>Yes</b>	<b>No</b>
<b>15. Been satisfied with the support my family/friends have given me</b>	<b>Yes</b>	<b>No</b>
<b>16. Found my relative/care recipient's living situation to be inconvenient or barrier to caregiving</b>	<b>Yes</b>	<b>No</b>

SAMPLE