

Health and Wellbeing Survey for Adults (16+)

What is the Survey About?

This survey is about your health and wellbeing and the community you live in. It will help us to identify the health needs of people in Havering. *The survey consists of 10 pages and should take no longer than 15 minutes to complete.*

Who Should Complete the Questionnaire

The questions should be answered by the person named on the front of the envelope. If that person needs help to complete the questionnaire, the answers should be given from his / her point of view – not the point of view of the person who is helping.

Completing the Questionnaire

- Please read each question carefully and place **X** in the relevant box to indicate the answer or answers you want to give.
- Please write clearly in blue or black ink inside the box.
- Please read the instructions given with each question, as some questions ask for only one answer, and others ask for more than one answer.
- Answer the next question unless asked otherwise.
- Once you have finished please take a minute to check you have answered all the questions that you should have answered.

Questions or Help

If you have any queries about the questionnaire please call the freephone survey helpline on 0800 783 1775.

Once you have completed the questionnaire please return it in the enclosed envelope as soon as possible. You do not need to add a stamp. If you cannot find or did not receive the pre-addressed envelope please send the questionnaire to:

Quality Health
Freepost Plus
RLXG-BXXG-HRXZ
PO Box 25
Chesterfield S44 5UT

Your participation in this survey is voluntary. If you choose to take part, your answers will be treated in confidence.

Your Health and Wellbeing

For each of the following questions, please mark **X** in the box that best describes your answer.

1. Have you been to see your family doctor (GP) in **the last 12 months**?
- | | | | | |
|----------------------------|----------------------------|---------------------------------|----------------------------------|----------------------------|
| No | Yes, in the last 4 months | Yes, between 5 and 8 months ago | Yes, between 9 and 12 months ago | Can't Remember |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

2. Have you been to your local accident and emergency department in **the last 12 months**?
- | | | | | |
|----------------------------|----------------------------|---------------------------------|----------------------------------|----------------------------|
| No | Yes, in the last 4 months | Yes, between 5 and 8 months ago | Yes, between 9 and 12 months ago | Can't Remember |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

3. Have you visited your local hospital as an outpatient in **the last 12 months**?
- | | | | | |
|----------------------------|----------------------------|---------------------------------|----------------------------------|----------------------------|
| No | Yes, in the last 4 months | Yes, between 5 and 8 months ago | Yes, between 9 and 12 months ago | Can't Remember |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

4. **By placing a tick in one box in each group below, please indicate which statements best describe your own health state today:**

a) Mobility

- | | |
|---------------------------------------|----------------------------|
| I have no problems in walking about | <input type="checkbox"/> 1 |
| I have some problems in walking about | <input type="checkbox"/> 2 |
| I am confined to bed | <input type="checkbox"/> 3 |

b) Self Care

- | | |
|---|----------------------------|
| I have no problems with self care | <input type="checkbox"/> 1 |
| I have some problems washing or dressing myself | <input type="checkbox"/> 2 |
| I am unable to wash or dress myself | <input type="checkbox"/> 3 |

c) Usual Activities

(e.g. work, study, housework, family or leisure activities)

- | | |
|--|----------------------------|
| I have no problems with performing my usual activities | <input type="checkbox"/> 1 |
| I have some problems with performing my usual activities | <input type="checkbox"/> 2 |
| I am unable to perform my usual activities | <input type="checkbox"/> 3 |

d) Pain / Discomfort

- | | |
|------------------------------------|----------------------------|
| I have no pain or discomfort | <input type="checkbox"/> 1 |
| I have moderate pain or discomfort | <input type="checkbox"/> 2 |
| I have extreme pain or discomfort | <input type="checkbox"/> 3 |

e) Anxiety / Depression

I am not anxious or depressed

I am moderately anxious or depressed

I am extremely anxious or depressed

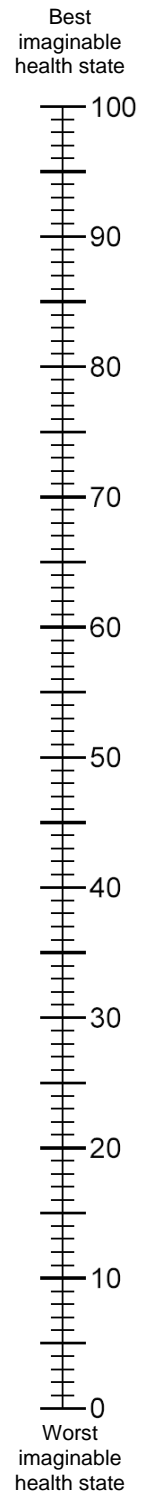
- 1
- 2
- 3

Your Own Health State Today

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this **by drawing a line from the box below** to whichever point on the scale indicates how good or bad your health state is today.

**Your own
health state
today**



General health over the past few weeks

We should like to know how your health has been in general over the **past few weeks**. Please answer ALL the questions simply by placing **X** in the box below the answer which you think most nearly applies to you. It is important that you try to answer ALL the questions.

Have you recently:

		Better than usual	Same as usual	Less than usual	Much less than usual
5.	been able to concentrate on whatever you're doing?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
		Not at all	No more than usual	Rather more than usual	Much more than usual
6.	lost much sleep over worry?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
		More so than usual	Same as usual	Less useful than usual	Much less useful
7.	felt that you are playing a useful part in things?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
		More so than usual	Same as usual	Less so than usual	Much less capable
8.	felt capable of making decisions about things?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
		Not at all	No more than usual	Rather more than usual	Much more than usual
9.	felt constantly under strain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
		Not at all	No more than usual	Rather more than usual	Much more than usual
10.	felt you couldn't overcome difficulties?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
		More so than usual	Same as usual	Less so than usual	Much less than usual
11.	been able to enjoy your normal day-to-day activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
		More so than usual	Same as usual	Less able than usual	Much less able
12.	been able to face up to your problems?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
		Not at all	No more than usual	Rather more than usual	Much more than usual
13.	been feeling unhappy and depressed?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
		Not at all	No more than usual	Rather more than usual	Much more than usual
14.	been losing confidence in yourself?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
		Not at all	No more than usual	Rather more than usual	Much more than usual
15.	been thinking of yourself as a worthless person?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
		More so than usual	About same as usual	Less so than usual	Much less than usual
16.	been feeling reasonably happy, all things considered?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Drinking Experiences

For each of the following questions, please mark **X** in the box that best describes your answer.

17. Do you ever drink alcohol **nowadays**, including drinks you brew or make at home? Yes No
 1 2

18. How old were you the first time you ever had a proper alcoholic drink? Write in how old you were then (e.g. 16).

If you have never had an alcoholic drink of any kind, please write **NEVER** and go to **question 26**.

19. Thinking now about all kinds of drinks, how often have you had an alcoholic drink of any kind **during the last 12 months**? Please place **X** in **one** box.

- | | | | |
|---------------------------|----------------------------|--|--|
| Almost every day | <input type="checkbox"/> 1 | Once or twice a month | <input type="checkbox"/> 5 |
| Five or six days a week | <input type="checkbox"/> 2 | Once every couple of months | <input type="checkbox"/> 6 |
| Three or four days a week | <input type="checkbox"/> 3 | Once or twice a year | <input type="checkbox"/> 7 |
| Once or twice a week | <input type="checkbox"/> 4 | I have not had an alcoholic drink in the last year | <input type="checkbox"/> 8 (go to Q26) |

20. On how many **days out of the last seven** did you have an alcoholic drink?

- | | | | | | | | |
|------|----------------------------|-----|----------------------------|-------|----------------------------|------|--|
| One | <input type="checkbox"/> 1 | Two | <input type="checkbox"/> 2 | Three | <input type="checkbox"/> 3 | Four | <input type="checkbox"/> 4 |
| Five | <input type="checkbox"/> 5 | Six | <input type="checkbox"/> 6 | Seven | <input type="checkbox"/> 7 | None | <input type="checkbox"/> 8 (go to Q26) |

21. Please think about **the day in the last week on which you drank the most**. Write in how much you drank **on that day: EXCLUDE NON-ALCOHOLIC OR LO-ALCOHOL DRINKS**.

a) Beer, stout, cider or shandy made from draught beer – exclude bottles / cans of shandy:

- | | None | One | Two to Four | Five to Seven | Eight or More |
|----------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Pints | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Large cans / bottles | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Small cans / bottles | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

b) Wines, fortified wines, spirits or liqueurs:

	None	One	Two to Four	Five to Seven	Eight or More
Glasses of wine	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Glasses of Martini / Sherry / Port	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Single shots of Spirits or Liqueurs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

c) Alcopops such as Reef, Bacardi Breezer, WKD or Smirnoff Ice:

	None	One	Two to Four	Five to Seven	Eight or More
Small cans / bottles	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

The next few questions are about how you feel about drinking alcohol. Please answer ALL the questions by placing **X** in the box next to the answer that you think most applies to you.

22. I have felt that I ought to cut down on my drinking Yes 1 No 2
23. I have felt ashamed or guilty about my drinking Yes 1 No 2
24. People have annoyed me by criticising my drinking Yes 1 No 2
25. I have had a drink first thing in the morning Yes 1 No 2

Healthy Eating

26. On average, how many **portions of vegetables** do you eat each day?
 (1 portion of vegetables is, for example, 3 heaped tablespoons of cooked vegetables such as carrots, cabbage, peas or sweetcorn, or one cereal bowl of mixed salad. Beans and other pulse vegetables, such as kidney beans, lentils and chick peas can count, but only once a day, however much you eat. You can include raw, cooked, frozen or tinned vegetables, but do not include potatoes.) **Please put X in one box.**

None	One	Two	Three	Four	Five or more
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

27. On average, how many **portions of fruit** do you eat each day?
 (1 portion of fruit is a medium apple, banana or orange; a handful of grapes, cherries or berries; a large slice of pineapple; 2 plums, apricots etc; 1 tablespoon of dried fruit; 1 medium glass of fruit juice.) **Please put X in one box.**

None	One	Two	Three	Four	Five or more
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

Smoking

28. Have you ever smoked? Yes 1 No 2 (go to Q32)

29. If YES, do you smoke now? Yes 1 No 2 (go to Q32)

30. Would you like help in trying to give up smoking? Yes 1 No 2 (go to Q32)

31. If YES, how would you like to give up smoking?
From the list below, please put **X** by all that apply:

Using nicotine patches / gum (N.R.T) * 1

Visiting stop smoking clinic 2

Talk to GP / Practice Nurse 3

Talk to Pharmacist 4

Give up on my own 5

Other (please state) _____

* NRT is Nicotine Replacement Therapy, available on prescription from a health professional.

Leisure

32. On average, how many times do you exercise **each week** for at least 30 minutes?
(This can be made up of 2 periods of 15 mins or 3 of 10 mins & include brisk walking, strenuous gardening, swimming, gym or vigorous housework)

Never	Once a week	Twice a week	Three Times a week	Four Times a week	Five Times or more
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

Family and friends

Thinking about your **family and friends**. By family we mean those who live elsewhere as well as those who live with you. Below are some comments people have made about their family and friends. Please say how far each statement is true for you.

Please answer ALL the questions; marking **X** in the box that you think most applies to you.

	Not true	Partly true	Certainly true
33. There are people I know – amongst my family or friends – who make me feel an important part of their lives.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
34. There are people I know – amongst my family or friends – who can be relied on no matter what happens.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Your neighbourhood

The following are questions about your immediate neighbourhood. By neighbourhood we mean your street or block.

- | | Most | Many | A few | None |
|--|-----------------------------------|----------------------------------|--|---|
| 35. Would you say that you trust (most, many, a few, none) of the people in your neighbourhood? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| 36. Would you say this neighbourhood is a place where neighbours look out for each other? | Yes
<input type="checkbox"/> 1 | No
<input type="checkbox"/> 2 | Don't know
<input type="checkbox"/> 3 | |
| 37. In the past 3 years , have you taken action in an attempt to solve a local problem? | | | Yes <input type="checkbox"/> 1 | No <input type="checkbox"/> 2 (go to Q39) |
| 38. If YES, what sort of action? | | | | |
| Written to local paper | | | Yes <input type="checkbox"/> 1 | No <input type="checkbox"/> 2 |
| Contacted an appropriate organisation to deal with the problem (e.g. the Council) | | | Yes <input type="checkbox"/> 1 | No <input type="checkbox"/> 2 |
| Contacted a local councillor or MP | | | Yes <input type="checkbox"/> 1 | No <input type="checkbox"/> 2 |
| Attended a protest meeting or joined an action group | | | Yes <input type="checkbox"/> 1 | No <input type="checkbox"/> 2 |
| Any other – please explain briefly _____ | | | | |
| 39. Do you do an activity to support someone (other than a member of your family) regularly (i.e. prepare a meal, complete forms, shop or volunteer for a charity)? | | | Yes <input type="checkbox"/> 1 | No <input type="checkbox"/> 2 |

About yourself

So that we understand the needs of Havering residents, it is important that we ask you a few questions about yourself. As with all the questions elsewhere in this survey, your answers will be **completely confidential**.

40. Are you: Male ¹ Female ²

41. What was your age on your last birthday? YEARS

42. How tall are you?

Feet	Inches

 OR Centimetres

43. How much do you weigh?

Stone	Pounds

 OR Kilogrammes

44. Which of these activities best describes what you are doing at present?

- Employee in full-time job (30 hours plus per week) 1
 - Employee in part-time job (under 30 hours per week) 2
 - Self-employed full or part-time 3
 - On a government supported training programme
(e.g. modern apprenticeship / training for work) 4
 - Full-time education at school, college or university 5
 - Unemployed and available for work 6
 - Permanently sick / disabled 7
 - Wholly retired from work 8
 - Looking after the home 9
 - Doing something else (please write in)
-

45. Please tell us about the housing you live in:
- I / we own our home outright 1
 - I / we are buying our home on a mortgage 2
 - I / we rent our home from the council / Homes in Havering 3
 - I / we rent our home from a Housing Association / Trust 4
 - I / we rent our home from a private landlord 5
 - I / we live in someone else's home 6
- Other – please give details _____

46. What is your Annual household income from all sources?
(please give a total for everyone who lives with you)

- Under £5,000 a year 1
- £5,000 to less than £10,000 a year 2
- £10,000 to less than £15,000 a year 3
- £15,000 to less than £20,000 a year 4
- £20,000 to less than £30,000 a year 5
- £30,000 to less than £50,000 a year 6
- £50,000 to less than £100,000 a year 7
- £100,000 or over a year 8

47. To which of these groups do you consider you belong to?

White

British 1

Irish 2

Any other white background 3

(PLEASE WRITE IN)

Black or Black British

Caribbean 12

African 13

Any other black background 14

(PLEASE WRITE IN)

Mixed

White and Black Caribbean 4

White and Black African 5

White and Asian 6

Any other mixed background 7

(PLEASE WRITE IN)

Chinese or Other Ethnic Group

Chinese 15

Any other ethnic group 16

(PLEASE WRITE IN)

Asian or Asian British

Indian 8

Pakistani 9

Bangladeshi 10

Any other Asian background 11

(PLEASE WRITE IN)

48. Do you have a long-standing physical or mental health problem? (Long-standing means anything that has troubled you over a period of time or that is likely to affect you over a period of time).

Yes, both a physical and a mental health problem 1

Yes, a physical health problem only 2

Yes, a mental health problem only 3

No 4 (go to Q50)

Don't know / not sure 5

49. Does this illness or disability limit your activities in any way?

Yes 1

No 2

50. Is there anything else you would like to add?
(PLEASE WRITE IN THE BOX BELOW)

THANK YOU for taking part in this survey

Please ensure that you have marked all of the relevant boxes and
return the questionnaire in the enclosed prepaid envelope

YOU DO NOT NEED A STAMP