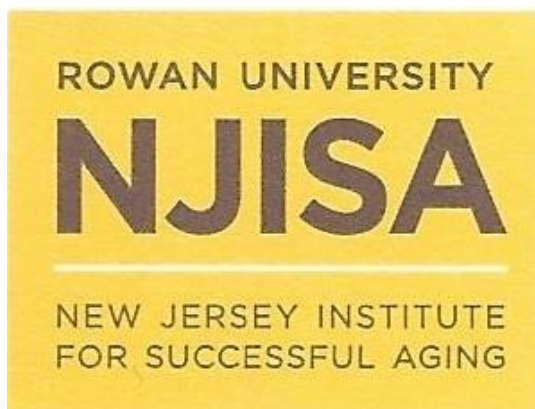


Time 5 Questionnaire



**Ongoing Research on Aging in New Jersey
Bettering Opportunities for Wellness in Life**



1. Please think about your aging experience. Using a scale from 0 to 10, where 0 means “Not well at all” and 10 means “Extremely well”, what number would you choose to describe how well you are aging?

Not well at all									Extremely well	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

2. How would you rate your overall health at the present time?

- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor

3. What is your height in feet and inches, without shoes?

_____ FEET _____ INCHES

4. How much do you weigh, in pounds, without shoes?

_____ POUNDS

5. Have you ever been told by a doctor or other health professional that you had:

	Yes	No		Yes	No
Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	IF YES → Are you taking any prescription medications for arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	IF YES → Are you taking any prescription medications for hypertension or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Any kind of heart condition or heart disease, such as coronary artery disease, angina, or heart attack (sometimes called coronary MI or myocardial infarction)?	<input type="checkbox"/>	<input type="checkbox"/>	IF YES → Are you taking any prescription medications for any kind of heart condition or heart disease, such as coronary artery disease, angina, or heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	IF YES → Are you taking any prescription medications for cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	IF YES → Are you taking any prescription medications for diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Osteopenia or osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>	IF YES → Are you taking any prescription medications for osteopenia or osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>
A stroke?	<input type="checkbox"/>	<input type="checkbox"/>	IF YES → Are you taking any prescription medications for a stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Lung or breathing problems, such as chronic bronchitis, asthma, or emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	IF YES → Are you taking any prescription medications for lung or breathing problems?	<input type="checkbox"/>	<input type="checkbox"/>
Depression, anxiety, or any other emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>	IF YES → Are you taking any prescription medications for depression, anxiety, or other emotional problem?	<input type="checkbox"/>	<input type="checkbox"/>
Any other chronic health condition? Please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>			

The next few questions are about your vision and hearing.

6. Do you wear glasses or contact lenses? (This includes prescription and non-prescription lenses, such as reading glasses.)

- No Yes

7. How would you rate your vision? (If applicable, please include when wearing your glasses or contacts, including prescription and non-prescription lenses, such as reading glasses.)

- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor

8. Do you use a hearing aid to help you hear?

- No Yes

9. How would you rate your hearing? (If applicable, please include when using your hearing aid.)

- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor

10. How difficult is it for you to:

	Not at all difficult	Only a little difficult	Somewhat difficult	Very difficult	You can't do it at all
Walk for a quarter of a mile, which is about 3 city blocks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk up 10 steps without resting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand or be on your feet for about 2 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit for about 2 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoop, bend, or kneel (including getting back up again afterwards)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach up over your head (such as reaching for an object on a shelf)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use your fingers to grasp or handle small objects?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift or carry something as heavy as 10 pounds, such as a full bag of groceries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push or pull large objects like a living room chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. In the last month, how much difficulty did you have...

	None	A little	Some	A lot	I didn't do it in the past month.
Doing laundry by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping for groceries or personal items by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making hot meals by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handling your bills and banking by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping track of your medicines by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving or taking public transportation by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Showering, taking a bath or washing up by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the toilet by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting dressed by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. How would you rate your memory at the present time:

- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor

13. In general, compared with the average person, how would you describe your memory:

- Much worse
- Somewhat worse
- About the same
- Somewhat better
- Much better

14. How much concern do you have about your memory at this time:

- Very serious concern
- A good deal of concern
- Some concern
- Only minor concern
- No concern at all

15. The next few questions are about sleep. How often do you...

	Most of the time	Sometimes	Rarely	Never
Have trouble falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have trouble with waking up during the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have trouble with waking up too early and not being able to fall asleep again?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel really rested when you wake up in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next few questions are about pain.**16. How often are you troubled with pain:**

- Almost always
- Often
- Sometimes
- Almost never

17. How bad is the pain most of the time: (If taking pain medication, rate severity of pain when medicated.)

- Mild
- Moderate
- Severe
- Not applicable (Almost never have pain)

18. How often does the pain make it difficult for you to do your usual activities such as household chores or work:

- Almost always
 Often
 Sometimes
 Almost never

19. Please indicate how often each statement has described you during the past week:

	Rarely or none of the time	Some or a little of the time	Occasionally or a moderate amount of the time	Most or all of the time
I was bothered by things that usually don't bother me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I had trouble keeping my mind on what I was doing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt depressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt that everything I did was an effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt hopeful about the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt fearful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My sleep was restless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt lonely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I could not get "going".	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next questions are about significant events you or your close family members may have experienced.

20. First, how many, if any, living children do you have? (Please include all biological, step, or adopted children.)

_____ CHILDREN

21. In the past 12 months...

	Yes	No	N/A
Did an adult child leave home? (Include a child leaving home for college.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did an adult child move back home with you? (Include a child moving home from college.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you move in with an adult child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. In the past 12 months...

	Yes	No
Did you lose a job unexpectedly?	<input type="checkbox"/>	<input type="checkbox"/>
Were you diagnosed with a major illness or condition?	<input type="checkbox"/>	<input type="checkbox"/>
Were you involved in an accident in which you were seriously injured?	<input type="checkbox"/>	<input type="checkbox"/>
Were you the victim of a crime?	<input type="checkbox"/>	<input type="checkbox"/>
Were you a victim of consumer fraud? (Note: This includes identity theft.)	<input type="checkbox"/>	<input type="checkbox"/>
Were you or a close family member arrested for violating the law?	<input type="checkbox"/>	<input type="checkbox"/>
Did a close family member become seriously ill or injured?	<input type="checkbox"/>	<input type="checkbox"/>
Did a close family member die?	<input type="checkbox"/>	<input type="checkbox"/>
Did a close friend die?	<input type="checkbox"/>	<input type="checkbox"/>
Did you gain a new close family member through marriage, birth, or adoption?	<input type="checkbox"/>	<input type="checkbox"/>
Did you stop driving a car?	<input type="checkbox"/>	<input type="checkbox"/>

23. In the past 12 months have you fallen down?

No Yes → How many times have you fallen in the past year?

_____ *FALLS*

When you fell, did you ever injure yourself seriously enough to need medical treatment?

No Yes

Did you ever fall...

	Yes	No
In your own home?	<input type="checkbox"/>	<input type="checkbox"/>
Outdoors?	<input type="checkbox"/>	<input type="checkbox"/>
In some other place (including other indoor places such as a friend's home or shopping center)?	<input type="checkbox"/>	<input type="checkbox"/>

24. The next few questions ask about some things that may have happened to you while you were a child or a teenager, before you moved out of your parents' house. Please indicate if any of these things have happened to you.

	Yes	No
Were you ever abused by someone close to you? (Please include physical, emotional, or sexual abuse.)	<input type="checkbox"/>	<input type="checkbox"/>
Did your father or mother not have a job for a long time when they wanted to be working?	<input type="checkbox"/>	<input type="checkbox"/>
Did your parents get a divorce?	<input type="checkbox"/>	<input type="checkbox"/>
Did either of your parents drink or use drugs so often that it caused problems for the family?	<input type="checkbox"/>	<input type="checkbox"/>
Was a household member depressed or mentally ill, or did a household member attempt suicide?	<input type="checkbox"/>	<input type="checkbox"/>

The next questions are about relationships.

25. Are you:

- Married
- Living with someone in a committed relationship
- Separated
- Divorced
- Widowed
- Single (never married)

26. Have you ever been divorced?

- No Yes → *MONTH:* _____ *YEAR:* _____

27. Have you ever been widowed?

- No Yes → *MONTH:* _____ *YEAR:* _____

If you are married or in a relationship answer the following:

28a. In what month and year did you get married to your spouse or become involved with your partner?

MONTH: _____ *YEAR:* _____

28b. How close is your relationship with your current spouse/partner? Would you say:

- Very close
- Somewhat close
- Not very close
- Not at all close

28c. How would you rate your spouse's/partner's overall health at the present time?

- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor

If you are married or in a relationship answer the following:

28d. How difficult is it for your spouse/partner to...

	Not at all difficult	Only a little difficult	Somewhat difficult	Very difficult	Can't do it at all
Walk for a quarter of a mile, which is about 3 city blocks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk up 10 steps without resting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand or be on their feet for about 2 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit for about 2 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoop, bend, or kneel (including getting back up again afterwards)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach up over their head (such as reaching for an object on a shelf)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use their fingers to grasp or handle small objects?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift or carry something as heavy as 10 pounds, such as a full bag of groceries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push or pull large objects like a living room chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. How often do you feel...

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
There is someone you can count on to listen to you when you need to talk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
That someone is available to give you good advice about a problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Someone shows you love and affection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is someone you can count on to provide you with emotional support in talking over problems or helping you make a difficult decision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. Do you currently *provide* help to anyone on a regular basis with tasks of daily life, such as driving, housework, bathing, or dressing?

- No Yes → To whom do you provide care:

	Yes	No
Spouse	<input type="checkbox"/>	<input type="checkbox"/>
Child (or child-in-law)	<input type="checkbox"/>	<input type="checkbox"/>
Parent	<input type="checkbox"/>	<input type="checkbox"/>
Sibling	<input type="checkbox"/>	<input type="checkbox"/>
Grandchild	<input type="checkbox"/>	<input type="checkbox"/>
Friend	<input type="checkbox"/>	<input type="checkbox"/>
Another person; What is his/her relationship to you? _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you live with this person/any of these people you provide care to?

- No Yes

31. Do you currently receive help from anyone on a regular basis with tasks of daily life, such as driving, housework, bathing, or dressing?

No Yes → To whom do you provide care:

	Yes	No
Spouse	<input type="checkbox"/>	<input type="checkbox"/>
Child (or child-in-law)	<input type="checkbox"/>	<input type="checkbox"/>
Parent	<input type="checkbox"/>	<input type="checkbox"/>
Sibling	<input type="checkbox"/>	<input type="checkbox"/>
Grandchild	<input type="checkbox"/>	<input type="checkbox"/>
Friend	<input type="checkbox"/>	<input type="checkbox"/>
Another person; What is his/her relationship to you? _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you live with this person/any of these people who you receive care from?

No Yes

32. The next questions are about how you feel about different aspects of your life. Please indicate how often you feel this way.

	Most of the time	Sometimes	Rarely	Never
How often do you feel that you lack companionship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel left out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel isolated from others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. Using a scale from 0 to 10, where 0 means “the worst possible life” and 10 means “the best possible life”, how would you rate your life these days?

The worst possible life

0 1 2 3 4 5 6 7 8 9 10

The best possible life

34. Indicate the extent to which you agree with each of the following statements.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I tend to bounce back quickly after hard times.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a hard time making it through stressful events.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It does not take me long to recover from a stressful event.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is hard for me to snap back when something bad happens.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually come through difficult times with little trouble.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I tend to take a long time to get over set-backs in my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35. Please indicate the extent to which you agree with each of the following statements.

	Strongly agree	Agree	Disagree	Strongly disagree
I have little control over the things that happen to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is really no way I can solve some of the problems I have.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is little I can do to change many of the important things in my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often feel helpless in dealing with the problems of life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes I feel that I'm being pushed around in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What happens to me in the future mostly depends on me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can do just about anything I really set my mind to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

36. How often has each of the following words described you in the past week:

	Never	Rarely	Sometimes	Often	Nearly Always
Happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warm-hearted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sad?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interested?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Annoyed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Content?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worried?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energetic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next questions are about exercise and other physical activities.

37. Over the past 30 days, did you do any vigorous exercise activities for at least 10 minutes? Some examples of vigorous exercise activities include running, lap swimming, aerobic exercising, water aerobics, or fast bicycling.

- No Yes → On average, how much time would you estimate you spend doing these vigorous activities each week? (If this is difficult, think about one day, then multiply that by the number of days you do this in a week.)

_____ *MINUTES* _____ *HOURS*

38. Over the past 30 days, did you do any moderate exercise activities for at least 10 minutes? Some examples of moderate exercise activities include brisk walking, bicycling for pleasure, gardening golfing, yoga, or dancing.

- No Yes → On average, how much time would you estimate you spend doing these moderate activities each week? (If this is difficult, think about one day, then multiply that by the number of days you do this in a week.)

_____ MINUTES _____ HOURS

39. Over the past 30 days, did you spend at least 10 minutes walking for leisure? Please include taking a walk for pleasure or taking a dog for a walk. Do not include brisk walking, jogging, or running.

- No Yes → On average, how much time would you estimate that you spend walking for leisure each week? (If this is difficult, think about one day, then multiply that by the number of days you do this in a week.)

_____ MINUTES _____ HOURS

40. Over the past 30 days, did you spend at least 10 minutes intentionally walking to get somewhere? Do not include daily walking around, brisk walking, jogging, or running; instead, focus on purposeful walking to go someplace.

- No Yes → On average, how much time would you estimate that you spend intentionally walking to get somewhere each week? (If this is difficult, think about one day, then multiply that by the number of days you do this in a week.)

_____ MINUTES _____ HOURS

41. Over the past 30 days, did you do any physical activities designed specifically to strengthen your muscles, such as lifting weights or doing push-ups or sit-ups? Please include all such activities, even if you had included them in your prior answers.

- No Yes → On average, how much time would you estimate that you spend doing these strengthening exercises each week? (If this is difficult, think about one day, then multiply that by the number of days you do this in a week.)

_____ MINUTES _____ HOURS

42. Do you smoke cigarettes:

- Every day
 Some days
 Not at all



On average, on the days you do smoke, how many cigarettes do you smoke per day?

_____ CIGARETTES

The next few questions are about preventive care.

43. In the past five years, have you had a colonoscopy?

No Yes

44. Now focusing on the past 12 months only.

	Yes	No
Did you receive a dental check-up?	<input type="checkbox"/>	<input type="checkbox"/>
Did you have an eye exam?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had your blood pressure taken by a doctor, nurse, or other health professional?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had your cholesterol levels checked?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a physical exam or regular check-up?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a flu shot?	<input type="checkbox"/>	<input type="checkbox"/>
Have you seen a counselor, psychologist, or psychiatrist?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a bone density test or Dexascan?	<input type="checkbox"/>	<input type="checkbox"/>
MALES ONLY: Have you had a prostate exam?	<input type="checkbox"/>	<input type="checkbox"/>
MALES ONLY: Have you had a blood test to screen your PSA level? (Prostate Specific Antigen)	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES ONLY: Have you had a breast exam performed by a doctor, nurse, or other health professional?	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES ONLY: Have you had a mammogram?	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES ONLY: In the past 3 years , have you had a pap smear?	<input type="checkbox"/>	<input type="checkbox"/>

45. How many visits, if any, have you made to a hospital emergency room during the past 12 months? Please include only those visits for which you were the patient.

_____ VISITS

46. Were you ever admitted to a hospital during the past 12 months? (Only include visits where you had to stay overnight.)

- No Yes → How many nights did you spend in a hospital during the past 12 months?

_____ *NIGHTS*

47. During the past 12 months did you spend any time in a physical rehab facility? (This includes short-term stays in a nursing home for rehabilitation.)

- No Yes → How many days were you in a physical rehab facility? _____ *DAYS*

Why were you admitted to a physical rehab facility? Select the answer that best describes your **primary** reason for needing rehab.

- Hip or knee replacement
- Other surgery (i.e., back)
- Accident (i.e., car accident)
- Fall
- Stroke
- Heart disease/condition
- COPD
- Cancer (i.e. post-chemo recovery)
- Pneumonia
- Other, please specify: _____

Now we have some questions about your neighborhood.

48. When you think about your neighborhood, do you think of the places located within:

- Less than 2 city blocks of your home
- About 1/4 mile—that is, 2 to 3 city blocks—of your home
- About 1/2 mile
- About 3/4 mile of your home
- About a mile
- About 2 miles
- Beyond 2 miles of your home

49. Next, please indicate whether you agree or disagree with these two statements about your neighborhood.

	Completely agree	Mostly agree	Just somewhat agree	Just somewhat disagree	Mostly disagree	Completely disagree
I feel safe being out alone in my neighborhood during the daytime .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel safe being out alone in my neighborhood at night .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

50. Please indicate the extent to which you agree or disagree with the following.

	Strongly agree	Agree	Disagree	Strongly disagree
There is a lot of graffiti in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My neighborhood is noisy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vandalism is common in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My neighborhood is clean.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are many interesting things to look at while walking in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stores are within easy walking distance at my home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are many places to go within walking distance at my home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is easy to walk to a transit stop (bus, train) from my home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

51. Does your neighborhood have...

	Not at all	Some	A lot
Walkable sidewalks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parks that are easy to get to and easy to use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Places to sit and rest at bus stops, in parks, or in other places where people walk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Curbs with curb cuts (i.e., breaks in curbs or ramps)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

52. Please indicate your level of agreement or disagreement with each of the following statements.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
People in this neighborhood are willing to help their neighbors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This is a close-knit neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People in this neighborhood can be trusted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People in this neighborhood generally <u>don't</u> get along with each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People in this neighborhood <u>do not</u> share the same values.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People in this neighborhood sit on their front porches or steps.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next questions focus on work and financial matters.

53. Are you:

- Fully retired
- Working full time
- Working part time
- A Homemaker (and not working or looking for work)
- In school (and not working or looking for work)
- Disabled (and not working or looking for work)
- Unemployed and looking for work
- Unemployed but not looking for work
- Something else; Please specify: _____

If you are retired or no longer working, please answer the following:

53a. In what month and year did you stop working?

MONTH: _____ *YEAR:* _____

53b. Did you stop working because of a health problem?

No Yes → Please specify: _____

53c. Did you stop working because of Hurricane Sandy?

No Yes

54. Would you say your total annual income from all sources, before taxes for all persons living in your household, including yourself would be:

- Less than \$15,000
- Between \$15,000 and \$30,000
- Between \$30,000 and \$50,000
- Between \$50,000 and \$80,000
- Between \$80,000 and \$150,000
- More than \$150,000

55. Since 2006, have you had a mortgage on your home?

- No
- Yes → Since 2006, have you fallen more than 2 months behind on mortgage payments?
 - No
 - Yes

The next set of questions are about the effects Hurricane Sandy had on your primary residence.

56. Thinking back to during or just after the storm, at any point did your home lose heat?

- No
- Yes → How long was your home without heat AFTER the hurricane?
_____ DAYS

57. At any point did your home lose hot water?

- No
- Yes → How long was your home without hot water AFTER the hurricane? (Answer in days; if 1 day or less, enter 1 below.)
_____ DAYS

58. At any point did your home lose electricity?

- No Yes → How long was your home without electricity AFTER the hurricane? (Answer in days; if 1 day or less, enter 1 below.)

_____ DAYS

59. Since Hurricane Sandy, has your house been affected by mold?

- No Yes

60. What happened to your neighborhood during the storm? Were/was there any...

	YES	NO
Fallen trees?	<input type="checkbox"/>	<input type="checkbox"/>
Downed power lines?	<input type="checkbox"/>	<input type="checkbox"/>
Disrupted public transportation?	<input type="checkbox"/>	<input type="checkbox"/>
Damaged homes?	<input type="checkbox"/>	<input type="checkbox"/>
Streets flooded?	<input type="checkbox"/>	<input type="checkbox"/>
Was water not drinkable (or potable)?	<input type="checkbox"/>	<input type="checkbox"/>

61. As a result of damage from Hurricane Sandy, did you apply for FEMA (Federal Emergency Management Agency) relief funds?

- No Yes

62. As a result of damage from Hurricane Sandy, did you file a claim with your insurance company?

- No Yes

63. Has your household income changed as a result of Hurricane Sandy?

- No Yes → Has your household income:
- Increased significantly
 - Increased somewhat
 - Decreased somewhat
 - Decreased significantly

64. Did you have a second home (vacation home) that was damaged by Hurricane Sandy?

- No Yes

65. During Hurricane Sandy, were you living alone?

- No Yes

66. When Hurricane Sandy hit in October 2012 where were you living?

ADDRESS 1: _____
ADDRESS 2 : _____
CITY : _____
STATE: _____
ZIP : _____

67. When did you begin living at this address? Please make your best guess.

MONTH: _____ YEAR: _____

68. Did you have to leave your home due to damage or the hardships caused by Hurricane Sandy? (Include any time out of your home even if only for one night.)

- No Yes → How long did you live or stay out of your primary residence because of Hurricane Sandy or were you never able to go back to that home?

_____ DAYS _____ MONTHS
 DID NOT RETURN TO HOME

Where did you live or stay during this time? (Select all that apply)

	Yes	No
With a relative	<input type="checkbox"/>	<input type="checkbox"/>
With a neighbor or friend	<input type="checkbox"/>	<input type="checkbox"/>
At a motel or hotel	<input type="checkbox"/>	<input type="checkbox"/>
Rented an apartment or other home	<input type="checkbox"/>	<input type="checkbox"/>
Bought or built new home	<input type="checkbox"/>	<input type="checkbox"/>
At a shelter	<input type="checkbox"/>	<input type="checkbox"/>
Other, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

69. Where were you living in _____?

ADDRESS 1: _____
 ADDRESS 2 : _____
 CITY : _____
 STATE: _____
 ZIP : _____

70. When did you begin living at this address? Please make your best guess.

MONTH: _____ YEAR: _____

75. At your current address, do you:

- Own your home
- Pay rent
- Live with a family member
- Have another living arrangement

76. Do you anticipate moving within the next year?

- No Yes

Now some questions about your home.

77. How many steps are at the entrance of your home that you use most often?

- None
- One or two
- 3 to 5
- 6 to 8
- More than 8

78. How many stories are in your home, including your basement?

- One
- Two
- Three
- Four or more

79. Which of the following are on the main level of your home:

	Yes	No
A bathroom with a tub or shower?	<input type="checkbox"/>	<input type="checkbox"/>
Your bedroom?	<input type="checkbox"/>	<input type="checkbox"/>
A place for washing and drying clothing?	<input type="checkbox"/>	<input type="checkbox"/>

80. Does your home have a sunken living room or family room? No Yes**81. Does your home have any of the following safety features:**

	Yes	No
Ramps?	<input type="checkbox"/>	<input type="checkbox"/>
Stair glides?	<input type="checkbox"/>	<input type="checkbox"/>
Hand rails or grab bars in bathroom?	<input type="checkbox"/>	<input type="checkbox"/>
Built-in seats in shower?	<input type="checkbox"/>	<input type="checkbox"/>
Raised toilets?	<input type="checkbox"/>	<input type="checkbox"/>
A walk-in shower or tub?	<input type="checkbox"/>	<input type="checkbox"/>

82. In your home...

	Rarely or none of the time	Some or a little of the time	Occasionally or a moderate amount of the time	Most or all of the time
How often do you have to reach up over your head to access items you need on a daily basis in your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have to stoop, bend, or kneel to access items you need on a daily basis in your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Without assistance, how often do you have problems getting into or out of the bathtub or shower in your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

83. How would you rate the physical condition your home is in?

- Excellent
 Very good
 Good
 Fair
 Poor
 Very poor

84. Do you use a...

	Yes	No
Cane or crutch?	<input type="checkbox"/>	<input type="checkbox"/>
Walker?	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair or electric scooter?	<input type="checkbox"/>	<input type="checkbox"/>

85. Do you drive?

- No
 Yes → Do you drive at night?
- Not at all
 Some
 A lot

86. Using a scale from 0 to 10 where 0 means “Not Successful At All” and 10 means “Completely Successful,” please indicate which number best describes your aging experience?**Not Successful At All**

- 0 1 2 3 4 5 6 7 8 9 10

Completely Successful

87. Please indicate your level of agreement or disagreement with each of the following statements.

	Agree Strongly	Agree Mostly	Agree A Little	Disagree A Little	Disagree Mostly	Disagree Strongly
In general, I look forward to each new day about as much as I always have.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think my daily life now is not nearly as interesting and fulfilling as it has been throughout most of my lifetime.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I may be getting along in years, but I continue to feel life is worth living about as much as I ever have.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel I no longer can engage in activities that bring me pleasure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Even though things may change, my life continues to be about as much fun as it always has been.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Considering the hand life dealt me, I feel that I have accomplished pretty much what I could have hoped for at this point in my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am not as happy now as I was when I was younger.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

88. Please indicate your level of agreement or disagreement with each of the following statements. Please try to be as honest and as accurate as possible, keeping in mind that there are no right or wrong answers.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I am not a worrier.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I like to have a lot of people around me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I don't like to waste my time daydreaming.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I try to be courteous to everyone I meet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I keep my belongings neat and clean.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often feel inferior to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I laugh easily.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Once I find the right way to do something, I stick to it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often get into arguments with my family and co-workers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I'm pretty good about pacing myself so as to get things done on time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When I am under a great deal of stress, sometimes I feel like I'm going to pieces.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I don't consider myself especially "light-hearted."	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am intrigued by the patterns I find in art and nature.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Some people think I'm selfish and egotistical.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am not a very methodical person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I rarely feel lonely or blue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I really enjoy talking to people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I believe letting students hear controversial speakers can only confuse and mislead them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would rather cooperate with others than compete with them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I try to perform all tasks assigned to me conscientiously.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often feel tense and jittery.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I like to be where the action is.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poetry has little or no effect on me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I tend to be cynical and skeptical of others' intentions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a clear set of goals and work toward them in an orderly fashion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes I feel completely worthless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually prefer to do things alone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often try new and foreign foods.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I believe that most people will take advantage of you if you let them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I waste a lot of time before settling down to work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I rarely feel fearful or anxious.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often feel as if I'm bursting with energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I seldom notice the moods or feelings that different environments produce.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most people I know like me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I work hard to accomplish my goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often get angry at the way people treat me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am a cheerful, high-spirited person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I believe we should look to our religious authorities for decisions on moral issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Some people think of me as cold and calculating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When I make a commitment, I can always be counted on to follow through.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Too often, when things go wrong, I get discouraged and feel like giving up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I am not a cheerful optimist.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes when I am reading poetry or looking at a work of art, I feel a chill or wave of excitement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I'm hard-headed and tough-minded in my attitudes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes I'm not as dependable or reliable as I should be.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am seldom sad or depressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My life is fast-paced.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have little interest in speculating on the nature of the universe or the human condition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I generally try to be thoughtful and considerate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am a productive person who always gets the job done.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often feel helpless and want someone else to solve my problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am a very active person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a lot of intellectual curiosity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I don't like people, I let them know it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I never seem to be able to get organized.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At times I have been so ashamed I just wanted to hide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would rather go my own way than be a leader of others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often enjoy playing with theories or abstract ideas.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If necessary, I am willing to manipulate people to get what I want.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I strive for excellence in everything I do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Thank you for your continued participation in the
ORANJ BOWLSM Research Program!**

**Please use the pre-addressed, postage-paid envelope provided
to return your completed questionnaire.**

You should receive your thank you gift in approximately 2-3 weeks.