Appendix H: Caregiver Questionnaire

Please CIRCLE a number from 1–5 to indicate your choice:

1. Do/did you feel overwhelmed by providing care?

Not at all	Somewhat	More often	Most often	All of the time
1	2	3	4	5

2. Do you feel isolated from family and friends?

Not at all	Somewhat	More often	Most often	All of the time
1	2	3	4	5

3. Are you worried about your ability to cope now or later?

Not at all	Somewhat	More often	Most often	All of the time
1	2	3	4	5

4. Are you feeling sad or depressed?

Not at all	Somewhat	More often	Most often	All of the time
1	2	3	4	5

5. Alcohol intake: _____________ (drinks per day / week)

6. Exercise: _____________ (sessions / week)

7. Sleep Change: Yes ☐ No ☐

8. Eating: More ☐ Less ☐

9. What changes have occurred in your life due to personal loss?

Source: Family Practice Oncology Network