Caregiver Baseline Survey

Thank you for participating in the BESI-C research project! Please answer the following questions to the best of your ability.

Please mark the response that best matches your experience.
Because we are interested in your individual perspective, please answer these questions independently (separate from your partner).

On a day-to-day basis, who is generally most responsible for managing and keeping track of the patient's pain medications?	◯ Patient ◯ Me, as the caregiver ◯ Both of us; we equally manage patient's pain medications
How confident are you in managing the patient's pain?	◯ Not at all ◯ A little ◯ Somewhat ◯ Quite ◯ Very ◯ I don't know
How effective, overall, do you think the patient's current pain regimen is at controlling their pain?	◯ Not at all ◯ A little ◯ Somewhat ◯ Quite ◯ Very ◯ I don't know
How much does the patient's pain interfere with your day-to-day activities?	◯ Not at all ◯ A little ◯ Somewhat ◯ Quite ◯ Very ◯ I don't know
Select the statement that best describes the patient today.	◯ The patient is fully active. ◯ The patient can't do heavy work but can do some light work. ◯ The patient can't do any work but can care for themselves. ◯ The patient needs some help caring for themselves and spends most of the day in bed or in a chair. ◯ The patient needs much help caring for themselves and spends nearly all day in bed or in a chair.
How long have you been the patient's primary caregiver?	◯ < 6 months ◯ 6 months - < 2 years ◯ 2 - < 5 years ◯ 5+ years

In your opinion, do you think the following help relieve the patient's pain?

	Yes	No	Don't know
Over the counter creams or ointments	◯	◯	◯
Ice/Heat	◯	◯	◯
Massage	◯	◯	◯
Exercise/activity/walking	◯	◯	◯
Listening to music/watching T.V.	◯	◯	◯
Comfortable or special position	◯	◯	◯
Being with other people	◯	◯	◯
Resting/sleep	◯	◯	◯
Progressive muscle relaxation/taking deep breaths	◯	◯	◯
Guided imagery/hypnosis	◯	◯	◯
Acupuncture/acupressure	◯	◯	◯
Prayer/Meditation	◯	◯	◯
Distracting activity, like sewing or handiwork	◯	◯	◯
Other	◯	◯	◯

Please specify what other activity helps the patient's pain.

_____

Do you have any of the following common medical problems?

Do you have heart disease?	◯ Yes	◯ No
Do you receive treatment for heart disease?	◯ Yes	◯ No
Does heart disease limit your activities?	◯ Yes	◯ No
Do you have lung disease?	◯ Yes	◯ No
Do you receive treatment for lung disease?	◯ Yes	◯ No
Does lung disease limit your activities?	◯ Yes	◯ No
Do you have cancer?	◯ Yes	◯ No
Do you receive treatment for cancer?	◯ Yes	◯ No
Does cancer limit your activities?	◯ Yes	◯ No
Do you have diabetes?	◯ Yes	◯ No
Do you receive treatment for diabetes?	◯ Yes	◯ No
Does diabetes limit your activities?	◯ Yes	◯ No
Do you have kidney disease?	◯ Yes	◯ No
Do you receive treatment for kidney disease?	◯ Yes	◯ No
Does kidney disease limit your activities?	◯ Yes	◯ No
Do you have liver disease?	◯ Yes	◯ No
Do you receive treatment for liver disease?	◯ Yes	◯ No
Does liver disease limit your activities?	◯ Yes	◯ No
Do you have ulcer or stomach disease?	◯ Yes	◯ No

Do you receive treatment for ulcer or stomach disease?	◯ Yes	◯ No
Does ulcer or stomach disease limit your activities?	◯ Yes	◯ No
Do you have depression or anxiety?	◯ Yes	◯ No
Do you receive treatment for depression or anxiety?	◯ Yes	◯ No
Does depression or anxiety limit your activities?	◯ Yes	◯ No
Do you have rheumatoid arthritis?	◯ Yes	◯ No
Do you receive treatment for rheumatoid arthritis?	◯ Yes	◯ No
Does rheumatoid arthritis limit your activities?	◯ Yes	◯ No
Do you have osteoarthritis?	◯ Yes	◯ No
Do you receive treatment for osteoarthritis?	◯ Yes	◯ No
Does osteoarthritis limit your activities?	◯ Yes	◯ No
Do you have other chronic pain?	◯ Yes	◯ No
Do you receive treatment for other chronic pain?	◯ Yes	◯ No
Does other chronic pain limit your activities?	◯ Yes	◯ No
Do you have a neurological disease (like Multiple Sclerosis)?	◯ Yes	◯ No
Do you receive treatment for a neurological disease (like Multiple Sclerosis)?	◯ Yes	◯ No
Does a neurological disease (like Multiple Sclerosis) limit your activities?	◯ Yes	◯ No
Do you have other medical problems?	◯ Yes	◯ No

Please specify your other medical problem(s).	_____
Do you receive treatment for your other medical problem(s)?	◯ Yes ◯ No
Do your other medical problems limit your activities?	◯ Yes ◯ No

Please tell us about your COVID-19 experience.

Have you ever had COVID-19?

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ Prefer not to answer

When did you have COVID-19?

- ◯ Less than 1 month ago
- ◯ 1-3 months ago
- ◯ 4-6 months ago
- ◯ More than 6 months ago
- ◯ Prefer not to answer

Do you continue to feel bad from COVID-19?

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ Prefer not to answer