# ACTG BASELINE PSYCHOSOCIAL ASSESSMENT

NIAID ADULT AIDS CLINICAL TRIALS GROUP



Patient Number ☐☐ ☐☐☐☐ ☐ Date of Patient Visit ☐☐☐ ☐☐ ☐☐☐☐
mmm dd yyyy

Protocol Number ☐☐☐☐☐☐ Institution Code ☐☐☐☐☐☐

Form Week ☐☐☐ *Seq No. ☐ **Step No. ☐ Key Operator Code ☐☐☐

* Enter a "1" if this is the first of this form for this date. Designate subsequent forms on same date with a 2, 3, etc.
**Enter the subject's current study step number. Enter '1' if the study does not have multiple steps.

**FOR OFFICE USE ONLY - DETACH THIS PAGE**

**INSTRUCTIONS TO THE STUDY PERSONNEL:**

The ACTG BASELINE PSYCHOSOCIAL ASSESSMENT should be given to the participant prior to the clinical exam. The participant must be able to read at the sixth-grade level at a minimum to complete the questionnaire without additional assistance.

It is important to be familiar with the content and format of the questionnaire before giving it to study participants. At the first visit, please begin by telling the participant:

- The purpose of this form is to assess potential factors associated with taking medications.
- Please answer all questions honestly; you will not be "judged" based on your responses.
- If you do not wish to answer a question, please draw a line through it.
- When completed, the form will be quickly reviewed to make sure you didn't mistakenly skip questions (without crossing them out); your specific responses to questions will not be reviewed.
- Please feel free to ask if you need any of the questions explained to you.

You should then briefly go over the format of the questions and how to complete them.
The questionnaire is very brief and should take approximately 10 minutes to complete. Before giving the participant the questionnaire, please fill out the header(s) and DETACH THIS PAGE.

Each question is in the same general format and contains several items. Note that the participant is always asked to make a "✓" next to the appropriate category.

Collect the completed questionnaire. Before going on, review the questionnaire for omissions.
If the participant missed any of the questions, point this out and encourage him/her to complete the omissions.

For data keying, if the participant did not answer a question, enter "-1." Do not leave any fields blank.

**PLEASE COMPLETE THE FOLLOWING ITEMS AFTER THE PARTICIPANT COMPLETES THE QUESTIONNAIRE OR AFTER YOU ASCERTAIN THAT THIS IS NOT POSSIBLE:**

1. How was the questionnaire completed? ..... 1-Self administered by the study participant
2-Face-to-face interview that you conducted
3-Both self-administered and interview
4-Not completed
9-Other, specify ☐

**If Other**, specify [30]: _____

a. If **"4-Not completed"**, indicate the reason: 1-Participant refused
2-Participant missed clinic visit
3-There was not enough time
9-Other reason, specify ☐

**If Other**, specify [30]: _____

06-23-03

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* Enter a "1" if this is the first of this form for this date. Designate subsequent forms on same date with a 2, 3, etc.
**Enter the subject's current study step number. Enter '1' if the study does not have multiple steps.

Your answers will be used to plan ways to help people who must take pills on a difficult schedule. Please do the best you can to answer all the questions. If you do not wish to answer a question, please draw a line through it. If you do not know how to answer a question, ask your study nurse for help. Thank you for helping in this important study.

**INSTRUCTIONS:** Please answer the following questions by placing a "✓" in the appropriate box.

***Please check one box for each question.***

A. How sure are you that: ***(Check one)***

| | Not At All Sure | Somewhat Sure | Very Sure | Extremely Sure |
|---|---|---|---|---|
| 1. You will be able to take all or most of your anti-HIV medication as directed? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 2. Anti-HIV medication will have a positive effect on your health? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 3. If you do not take anti-HIV medication exactly as instructed, the HIV in your body will become resistant to HIV medications? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

B. The following questions ask about sources of support. ***(Check one)***

| | Very Dissatisfied | Somewhat Dissatisfied | Somewhat Satisfied | Very Satisfied |
|---|---|---|---|---|
| 1. In general, how satisfied are you with the overall support you get from your friends and family members? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

| | Not At All | A Little | Somewhat | A Lot | Not Applicable |
|---|---|---|---|---|---|
| 2. To what extent do your friends or family members help you remember to take your medication? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

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mmm dd yyyy

C. The following questions ask about your HIV health care provider(s).
(Medical doctor, nurse practitioner, or physician's assistant that you see **most often** for your HIV care.)

*(Check one)*

| In general, how much… | Not At All | A Little | Somewhat | A Lot | Don't Know |
|---|---|---|---|---|---|
| 1. …do(es) your HIV provider(s) know about taking care of complex medical problems like yours? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 2. …do you trust your HIV provider(s) to provide you with high quality care? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 3. …do(es) your HIV provider(s) understand how your health problems affect your day to day life? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

| | Excellent | Very Good | Good | Fair | Poor |
|---|---|---|---|---|---|
| 4. Overall, how would you rate the care you receive from your HIV provider(s)? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

D. In the **past week** how often did you:

*(Check one)*

| | Never/ Rarely | Sometimes | Often | Mostly or Always |
|---|---|---|---|---|
| 1. Feel like you couldn't shake off the blues even with help from your family or friends? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 2. Have trouble keeping your mind on what you were doing? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 3. Feel that everything you did was an effort? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 4. Have trouble sleeping? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 5. Feel lonely? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 6. Feel sad? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 7. Feel like you just couldn't "get going"? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

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E. In the **past month**, how often have you:

| | Never | Almost Never | Some-times | Fairly Often | Very Often |
|---|---|---|---|---|---|
| | *(Check one)* | | | | |
| 1. Been upset because of something that happened unexpectedly? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 2. Felt unable to control the important things in your life? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 3. Felt nervous and "stressed"? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 4. Felt confident in your ability to handle your personal problems? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 5. Felt that things were going your way? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 6. Found that you could not cope with all the things that you had to do? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 7. Been able to control irritations in your life? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 8. Felt that you were on top of things? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 9. Been angered because of things that happened that were outside of your control? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 10. Felt problems were piling up so high that you could not overcome them? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

F. Are you currently taking medications or being treated (e.g., seeing psychologist or counselor) for depression or other mental health problems?

☐ Yes 1 ☐ No 2

Language: English ☐ E

06-23-03

Date Form Keyed (DO NOT KEY): _____ / _____ / _____