

HEALTH, WELL-BEING AND SERVICE USE - National Study of the Adult Finnish Population (ATH)


Please respond to this questionnaire as soon as possible, preferably within 10 days. Return your response in the enclosed envelope; no stamp is needed.

You may also fill in the questionnaire online at www.thl.fi/ath/vastaa. To log in, you will need the form code – the number at the top of the covering letter. Your password is in the covering letter.

Thank you for your time!

INSTRUCTIONS TO RESPONDENTS

Answer the questions as follows:

- Tick the most suitable alternative or write the information required in the space given with a ballpoint pen.
-  If you make some marks to an answer box which you do not mean, please blacken the entire answer box.
- You should only tick one best alternative for each question unless it is specifically stated that you may select more than one alternative.
- There are further instructions for some questions. Remember to answer all questions. Enter negative answers by ticking the 'no' alternative or by writing '0' (zero) in the space provided.

EXAMPLE 1.

How would you evaluate your state of health at present?

- very good
- fairly good
- fair
- fairly poor
- poor

EXAMPLE 2.

Give your present height and weight

height 1 6 5 cm

weight 6 2 kg

Further information about the study:

ATH toll-free number 0800 97730 (9.00–11.00)

e-mail: ath-info@thl.fi

www.thl.fi/ath/osallistuvalla (in Finnish)

CONSENT TO PARTICIPATE IN THE ATH STUDY

I have read and understood the leaflet “*Information for study participants*”, and I have received a sufficiently comprehensive account of the research and of the collection, processing, linkage and disclosure of data performed as part of the Study.

I understand that my participation in the Study is voluntary.

By responding to this survey I confirm my participation in the Study.

BACKGROUND INFORMATION

1. Are you currently:

- married or in a registered relationship
- cohabiting
- separated or divorced
- widowed
- single

2. How many years altogether have you attended school or studied full time?

Including primary and comprehensive school.

_____ years

3. What is your form of accommodation at the moment:

- owner-occupied housing
- rented accommodation
- sheltered accommodation, rehabilitation home or retirement home
- other, where: _____

4. Do you live alone

- yes
- no, please enter the ages of **other** members of your household:

_____, years, _____, years, _____, years, _____, years, _____, years,

_____, years, _____, years, _____, years, _____, years, _____, years

5. At the moment, are you principally: *Please choose the option that best describes your situation*

- employed full-time
- employed part-time
- retired on an old age pension
- receiving a disability pension or rehabilitation benefit
- on part retirement
- unemployed or laid off, length of current period in months: _____
- on family leave, or a stay-at-home mother/father
- a student
- Other, describe: _____

6. Have you within the past 12 months ever:

| | no | yes |
|---|--------------------------|--------------------------|
| feared that you will run out of food before you can get money to buy more | <input type="checkbox"/> | <input type="checkbox"/> |
| been unable to buy medicines because you did not have any money | <input type="checkbox"/> | <input type="checkbox"/> |
| not visited a doctor because you did not have any money | <input type="checkbox"/> | <input type="checkbox"/> |

7. Does any of the following occur near your home, and if so, to what extent do they bother you?

| | no | yes, but does not bother me | bothers me slightly | bothers me a lot |
|---|--------------------------|-----------------------------|--------------------------|--------------------------|
| dangerous intersections and/or traffic routes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| slippery pedestrian paths in winter | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| poorly lit traffic routes/roads and paths | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| traffic or industrial noise, smell or dust | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| long distances to health services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| long distances to other services (e.g. shops) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| poor public transport | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HEALTH

8. How tall are you? _____ cm *please round to nearest centimeter*

9. How much do you weigh when wearing light clothing? _____ kg *please round to nearest kilogram*

10. How would you describe your state of health at present?

- good
- fairly good
- average
- fairly poor
- poor

11. Do you have any longstanding illness or health problem?

- yes
- no

12. Are you limited because of a health problem in activities people usually do? Would you say you are...

- severely limited
- limited but not severely
- not limited at all (*proceed to question 14*)

13. Have you been limited for at least the past 6 months?

- yes
- no

14. How many whole days have you been absent from work or unable to perform your regular tasks during the past year (12 months)?

If you are unable to remember precisely, an estimate suffices. Do not include pregnancy-related absences.

_____ days

15. Have you had any of the following conditions diagnosed or treated by a doctor over the past 12 months?

| | yes |
|--|--------------------------|
| high blood pressure, hypertension | <input type="checkbox"/> |
| high blood cholesterol | <input type="checkbox"/> |
| arthrosis of the back, sciatica, lower back pain or other back condition | <input type="checkbox"/> |
| depression | <input type="checkbox"/> |
| other mental health problem | <input type="checkbox"/> |
| asthma | <input type="checkbox"/> |
| diabetes | <input type="checkbox"/> |
| hay fever or other allergic rhinitis | <input type="checkbox"/> |
| none of the above mentioned illnesses | <input type="checkbox"/> |

16. Have you had any of the following symptoms or troubles over the past 30 days?

| | yes |
|--------------------------------------|--------------------------|
| headache | <input type="checkbox"/> |
| joint ache | <input type="checkbox"/> |
| neck and shoulder problems | <input type="checkbox"/> |
| back pain | <input type="checkbox"/> |
| insomnia | <input type="checkbox"/> |
| incontinence | <input type="checkbox"/> |
| tinnitus (ringing in the ears) | <input type="checkbox"/> |
| none of the above mentioned symptoms | <input type="checkbox"/> |

The next five (5) questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please circle the one answer that comes closest to the way you have been feeling.

17. Over the past 4 weeks, for how much of the time have you felt:

Please choose one alternative on each line.

| | all of the time | most of the time | a good bit of the time | some of the time | a little of the time | not at all |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| very nervous | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| in such a low mood that nothing could cheer you up | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| calm and peaceful | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| downhearted and sad | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| happy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

18. Do you ever feel lonely:

- never
- very rarely
- sometimes
- fairly often
- all the time

19. Over the past 12 months, have you ever had a period of two weeks or more when you have felt most of the time:

| | no | yes |
|--|--------------------------|--------------------------|
| down, melancholic or depressed | <input type="checkbox"/> | <input type="checkbox"/> |
| that you have lost your interest in most things that usually give you pleasure (hobbies, work, and other activities) | <input type="checkbox"/> | <input type="checkbox"/> |

The following question deal with thoughts and feelings regarding harming yourself. Some people experience difficulties in their lives that prompt such thoughts and feelings.

20. Have you thought about suicide over the past 12 months?

- no
- yes

FUNCTIONAL AND WORKING CAPACITY

21. How often are you in contact in the following ways with your friends and relatives who do not live in the same household with you?

| | daily or almost daily | 1-3 times a week | 1-3 times a month | less than once a month | never |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| meeting in person | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| by phone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| over the Internet (e-mail, chat, Skype, Facebook, etc.) or by letter | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

22. Do you participate in the activities of any club, association, hobby group or religious or spiritual community (sports club, residents' association, political party, choir, parish)?

- no
- yes, actively
- yes, occasionally

23. Please estimate how you would expect to receive help from the following when you need help or support. You may choose one or more alternatives on each line.

| | spouse, partner | other next of kin | close friend | close colleague | close neighbour | other person close to you | no one |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------|--------------------------|
| who do you believe truly cares about you, whatever may happen? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| who will provide practical help when you need it? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

24. Do you regularly help someone living in your household who has limited functional capacity, or is ill, to cope at home? You can choose multiple options.

- no (proceed to question 26)
- yes, my spouse
- yes, my child or grandchild
- yes, my own or my spouse's parents
- yes, my own or my spouse's grandparents
- yes, some other person, whom? _____

25. Are you a formally appointed informal caregiver? (contract signed)

- no
- yes

26. Did you vote in the most recent elections:

| | no | yes | I don't remember |
|------------------------------|--------------------------|--------------------------|--------------------------|
| local election | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parliament election | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| presidential election | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| European Parliament election | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

27. Can you usually perform the following actions?

| | yes, no problem | yes, with some difficulty | yes, but with great difficulty | no, I cannot |
|--|--------------------------|---------------------------|--------------------------------|--------------------------|
| run a short distance (about 100 m) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| walk about 500 m without stopping to rest | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| read ordinary newspaper print (with or without spectacles) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| follow a conversation between several people (with or without a hearing aid) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

28. The following questions concern memory, learning and concentration:

| | very well | well | adequately | poorly | very poorly |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| How well does your memory work? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How easily do you learn new things? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How well can you concentrate on things? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

29. What is/was your most recent job like?

| | light | fairly light | a bit strenuous | quite strenuous | very strenuous | I have never been in paid employment |
|------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------------------|
| physically | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| mentally | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

30. Are the following statements about home and work accurate for you? Please select the most suitable option for you in each section.

| | completely accurate | fairly accurate | fairly inaccurate | completely inaccurate | don't know / not applicable |
|--|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|
| when I come home, I stop thinking about my work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel I am neglecting domestic issues because of my work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I sometimes neglect my family when I am wholly absorbed in my work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I often find it difficult to concentrate on my work because of domestic issues | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have more energy to be with the children when I also go to work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

31. Assuming that the best working capacity you have ever had would score 10 on a scale of 0 to 10, how would you score your working capacity at present? Please tick the number that best applies to your working capacity.

| No working capacity | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Best working capacity |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <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"/> | <input type="checkbox"/> | <input type="checkbox"/> |

32. How do you assess your current working capacity? If you are not employed at present, please answer as for your most recent job.

| | very good | fairly good | fair | fairly poor | very poor | I have never been in paid employment |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------------------|
| considering the physical demands of your work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| considering the mental demands of your work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

33. Do you think that your health will allow you to work until retirement age?

- no
- probably not
- probably yes
- yes
- I am retired

34. How physically strenuous is your work? Please choose the alternative that best fits your situation.

- I am not employed; or, my work is mainly done sitting down, and I do not walk a lot
- I walk quite a lot in my work but do not have to lift or carry heavy loads
- I have to lift and carry a lot in my work or walk up stairs or up hills
- my work is physically heavy; I have to lift and carry heavy loads or dig, shovel, chop, etc.

LIFESTYLE

The following three questions (35-37) concern how you get exercise at work, on the way to work and in your leisure time. If you exercise in different ways at different times of the year, please select the alternative that best describes your average situation.

35. How much do you exercise and strain yourself physically in your free time?

Exercise on the way to and from work/study not included.

- I read, watch TV and do things that are not very strenuous physically
- I walk, cycle or do light housework and gardening, etc., several hours a week
- I engage in exercise or sport such as running, skiing, swimming or ball games, several hours a week

36. How often do you engage in leisure exercise for a period of at least 30 minutes after which you are at least slightly out of breath and sweating? Exercise on the way to and from work/study not included.

- daily
- 4-6 times a week
- 3 times a week
- 2 times a week
- once a week
- 2-3 times a month
- a few times during the year or less
- I cannot exercise because of an illness or injury

37. For how many minutes do you walk or cycle on your way to and from work?

Note! Refers to the time used travelling to and from work in total

- I'm not working or I work at home
- I only use motor vehicles
- less than 15 minutes per day
- 15-30 minutes per day
- 30-60 minutes per day
- over an hour per day

38. How often have you eaten and drunk the following types of food or drink over the past 7 days?

| | never | on 1-2 days | on 3-5 days | on 6-7 days |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| fatty cheeses (e.g. Edam, Emmental, Oltermanni) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| low-fat cheeses (e.g. Polar-15, Edam 17, cottage cheese) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| fish | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| fresh vegetables or green salad | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| cooked vegetables (excluding potatoes) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| fruit or berries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| hamburgers, pizza, savoury pies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| buns, Danish pastry, biscuits, cakes, etc. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| chocolate or other sweets | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| juices with added sugar or soft drinks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| dark bread (rye bread, rye crispbread, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| vegetable oil or liquid margarine (e.g. Flora Culinesse) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| butter or buttermargarine mixture (e.g. Oivariini) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| margarine (e.g. Flora, Keiju) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| skimmed milk or buttermilk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

39. Can you have a meal at the canteen at your workplace or educational institution?

- yes
- no
- I am not employed and not studying

40. How often do you usually brush your teeth / dental prostheses?

- more than twice a day
- twice a day
- once a day
- not every day
- never

41. Has any of the persons mentioned below encouraged you to do any of the following over the past 12 months? *You may choose more than one alternative on each line.*

| | no one | doctor or dentist | a Public Health Nurse, or some other health care professional | family member | someone else |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| exercise more | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| change your dietary habits for health reasons | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| lose weight | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| drink less alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| quit smoking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

42. How many hours do you usually sleep during the night?

On average _____ hours

43. Do you feel that you get enough sleep?

- yes, almost always
- yes, often
- rarely or hardly ever
- don't know

44. Have you ever smoked?

- no (*if you have not smoked, proceed to question 47*)
- yes

45. Have you ever smoked daily for a period of at least one year? For how many years altogether?

- I have never smoked daily
- I have smoked daily for a total of _____ years

46. Do you smoke at the moment (cigarettes, cigars or pipe)?

- yes, daily
- occasionally
- not at all

47. Do you currently use snuff?

- yes, daily
- occasionally
- not at all currently
- I have never used snuff

48. Do you currently use electronic cigarettes (e-cigarettes)?

- yes, daily
- occasionally
- not at all currently
- I have never used electronic cigarettes

49. Have you drunk alcoholic beverages over the past 12 months?

- no (*proceed to question 54*)
- yes

50. How often do you consume alcoholic beverages? *Include the times when you only had a small amount, e.g. a bottle of medium beer or a sip of wine. Choose the option that best describes your situation.*

- never
- monthly or less
- 2 to 4 times a month
- 2 to 3 times a week
- 4 or more times a week

ONE ALCOHOL PORTION IS:
 1 bottle (33cl) of medium strength beer or cider, or
 1 glass (12cl) of usual mild wine, or
 1 small glass (8cl) of fortified wine, or
 a standard drink (4cl) of strong spirits

51. How many drinks containing alcohol do you have on a typical day when you are drinking?

Please refer to the adjacent box.

- 1 or 2
- 3 or 4
- 5 or 6
- 7, 8 or 9
- 10 or more units

EXAMPLES:
 0,5 l ('pint') of medim beer or cider = 1.5 units
 0,5 l ('pint') of stronger A beer or strong cider = 2 units
 0,75 l bottle of table wine (12%) wine = 6 units
 0,5 l bottle of spirits = 13 units

52. How often do you have six or more drinks on one occasion?

- never
- less than monthly
- monthly
- weekly
- daily or almost daily

53. How many glasses, bottles or restaurant servings of the following types of alcoholic beverages have you consumed over the past 7 days? *If you have consumed none, please enter 0.*

| | over the past 7 days |
|--|--|
| medium strength (III) beer, medium cider or long drinks <i>(sold in food shops, alcohol content 2.9% to 4.7%)</i> | _____ bottles (à 33 cl) |
| stronger A beer, strong cider or long drinks (only sold in Alko shops, alcohol content over 4.7%) | _____ bottles (à 33 cl) |
| wine | _____ glass (1 glass = appr. 12 cl) |
| spirits or other strong drinks | _____ restaurant portions (appr. 4 cl) |

54. Have you used cannabis (hashish, marijuana)?

- I have never tried it
- Yes, in the past 12 months
- Yes, but not in the past 12 months

The following questions concern gambling. In the following, GAMBLING concerns money games – lotteries such as Lotto or Keno, slot machines such as fruit machines, scratchcard lotteries, betting on sports and horse races, games run by Veikkaus, betting, casino games and Internet gambling such as online poker.

55. During the last 12 months, have you felt that gambling might be a problem for you?

- I do not play money games
- never
- sometimes
- often
- almost always

ACCIDENTS AND VIOLENCE

56. Have you sustained injuries in an accident over the past 12 months? How did the accident occur, and what treatment did you receive? You may choose more than one option.

| | no | yes, home treatment | yes, treatment by a nurse | yes, treatment by a doctor | yes, treatment in a hospital |
|--------------------------------------|--------------------------|--------------------------|---------------------------|----------------------------|------------------------------|
| at work or on my way to or from work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| at home, in free time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| in free time, while exercising | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| elsewhere in free time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

57. Do you use the following protective equipment?

| | always | often | sometimes | not at all | not applicable |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| helmet when riding a bicycle | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| safety belt on the back seat of a car | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| life jacket or other flotation device in a boat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| studded footwear or ice grips when walking outdoors in slippery conditions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| reflector when it is dark | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

58. Has anyone behaved violently towards you over the past 12 months?

You can choose multiple options.

| | no one | unknown person or casual acquaintance | present spouse, cohabitant or partner | other person well known to you (other family member, ex-spouse, friend, close acquaintance, colleague) |
|---|--------------------------|---------------------------------------|---------------------------------------|--|
| threats of physical harm made over the phone, in a letter or online | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| threats of physical harm made in person | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| obstruction of movement, grabbing, pushing or shoving | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| slapping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| hitting with a fist or a hard object, kicking, strangling or using a weapon | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| forced sexual intercourse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| forced other sexual activity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| attempt at forced sexual intercourse or other sexual activity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| other violent behaviour, please describe in one word: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

59. Have strangers on the street or elsewhere in a public place (e.g. in a shop, restaurant) treated you unfairly over the last 12 months?

- yes
- no

60. Has your own supervisor, colleague or customer at work treated you unfairly over the last 12 months?

- yes
- no
- I have not been employed during the past 12 months

QUALITY OF LIFE

When answering questions number (61-63), please consider the past two weeks.

61. How would you rate your quality of life?

- very poor
- poor
- neither poor nor good
- good
- very good

62. How satisfied are you with:

| | very dissatisfied | dissatisfied | neither satisfied nor dissatisfied | satisfied | very satisfied |
|--|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|
| your health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| your ability to perform your daily living activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yourself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| your personal relationships | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| the conditions of your living place | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

63. In the last two weeks, how completely were you able to do the following

| | not at all | a little | moderately | mostly | completely |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| do you have enough energy for everyday life? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| have you enough money to meet your needs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SERVICES

64. What is your opinion of the following statements regarding social welfare and health care services

| | completely agree | somewhat agree | neither agree nor disagree | somewhat disagree | strongly disagree |
|--|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| In general, health services function well in Finland | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| In general, social welfare services function well in Finland | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

65. Do you feel you have been adequately provided with the following social and health care services or benefits over the past 12 months? Please note services provided by the local authority and private service providers.

| | no need | I would have needed, but service or benefit was not received | the service or benefit was provided, but was not adequate | I have received adequate services or benefits |
|---|--------------------------|--|---|---|
| reception services of a doctor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| reception services of a nurse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| dentist services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| services for the disabled (e.g. transportation services, personal assistance, apartment alteration work) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| maternity and child health clinic services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| other services for families with children (e.g. child welfare services, parenting and family counselling clinic, home services) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| social worker's guidance and counselling services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| support services for informal caregivers (e.g. possibility to take time off) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| care fee for informal care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| social assistance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

66. Have the following factors interfered with you receiving the health services you needed over the last 12 months?

| | always | usually | sometimes | never | not applicable |
|--------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| difficult travel | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| high customer fees | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

67. Have the following factors interfered with you receiving the social services you needed over the last 12 months?

| | always | usually | sometimes | never | not applicable |
|--------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| difficult travel | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| high customer fees | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

68. How many times over the past 12 months have you gone to see a doctor or nurse or seen a doctor or nurse at your home because of an illness you yourself have or had (or because of pregnancy or childbirth)? Do not include those times when you were admitted to a hospital, if any.

| | never | once | 2-3 times | 4-6 times | more than 6 times |
|----------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| I saw a doctor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I saw a nurse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

69. How many times over the past 12 months have you had contact with the following:

| | never | once | 2-3 times | 4-6 times | more than 6 times |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| By phone | | | | | |
| with a doctor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| with a nurse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| with another health care professional | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| with a social worker or social instructor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Via electronic services | | | | | |
| with a doctor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| with a nurse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| with another health care professional | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| with a social worker or social instructor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

70. Have you used the possibility to change your health centre (public health care) over the past 12 months? The service is considered to be public in this context also when the municipality has selected a private service provider to be responsible for some of the health centre's services.

- I have not used the services of the health centre during the past 12 months
- I have not changed my health centre
- I have changed my health centre

71. Have you used the possibility to select or change your hospital (public health care) over the past 12 months? The service is considered to be public in this context also when the municipality has selected a private service provider to be responsible for some of the hospital treatments.

- I have not needed treatment or examinations at a specialised medical care outpatient clinic or inpatient ward over the past 12 months
- I have not selected or changed my hospital
- yes, I have selected or changed my hospital

72. How do the following statements describe your experiences of health services when you have used them over the past 12 months?

| | always | most of the time | sometimes | never | does not apply to me (I have not used health services) |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--|
| I was taken into care without undue delay | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I was examined without undue delay | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| the end result of the service corresponded to the need | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| my problem was handled smoothly and information run between professionals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

73. Over the past 12 months, how many times have you visited:

| | never | once | 2-3 times | 4-6 times | more than 6 times |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| dentist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| the surgery of a dental assistant or dental hygienist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

74. Have you been vaccinated against influenza over the past 12 months?

- no
- yes

75. When have you last had the following measurements taken by a health care professional?

Choose one alternative in every row.

| | during the past 12 months | 1 to 5 years ago | more than 5 years ago | never | don't know |
|-------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| blood cholesterol level | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| blood sugar level | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| waist circumference | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| weight | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

76. Have you had any of the following screenings or examinations over the past 5 years?

| | no | yes, during the past 1 year | yes, during the past 1–5 years |
|---|--------------------------|-----------------------------|--------------------------------|
| mammography (screening test for breast cancer), women | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PAPA test (cervical cancer screening) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PSA screening from blood sample related to prostate examination (men) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

77. Over the past 12 months, have you visited any of the following because of mental health problems or intoxicant abuse problems:

| | no | yes, because of mental health problems | yes, because of drug abuse problems |
|---|--------------------------|--|-------------------------------------|
| outpatient care (e.g. occupational health care, A clinic, mental health clinic) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| institutional care (e.g. psychiatric hospital or other hospital for detoxification) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

78. Which social services have you last used over the past 12 months?

Please select one option based on the service you have used most recently.

- services for the elderly (e.g. housing services, home services, residential homes)
- services for the disabled (e.g. transportation services, personal assistance, apartment alteration work)
- services for families with children (e.g. child welfare services, home services, parenting and family counselling clinic)
- guidance or advice given by a social worker
- none of the above (*proceed to question 80*)

79. How do the following statements describe your experiences of social welfare services over the past 12 months? Please assess the service you have used most recently.

| | always | most of the time | sometimes | never | does not apply to me (I have not used social welfare services) |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--|
| my problem was handled without undue delay | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| the end result of the service corresponded to the need | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| my problem was handled smoothly and information run between professionals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

In this section, we ask you about your views of e-services in the social and health care system. Even if you have not used social and health care e-services so far, your views are extremely valuable to us when we develop the services to meet the citizens' needs better. E-services include My Kanta services, e-services for booking appointments, online information about health, risks of illnesses and the offer of services, as well as arrangements for contacting professionals via the Internet.

80. Do you use the Internet for the following:

| | no | yes |
|--|--------------------------|--------------------------|
| e-transactions (online banking, social insurance institution [Kela], taxoffice, ticket sales, local public services, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| finding information (timetables, health information, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |

81. What is your assessment of your ability to use the internet - online services (on computer or mobile devices)?

- I do not use them
- novice (I use them with assistance)
- I use the basic services independently
- I use many online applications effortlessly
- expert (I can teach others)

82. How have you been doing the following things during the past year? *If electronic services replaced making a visit or a call, please also estimate how many times. You can choose between the traditional (paper, visit or phone call) and the electronic service use (via mobile devices or computer).*

| | no | yes traditionally | yes electronically | electronic services replaced a visit or call: how many times? |
|--|--------------------------|--------------------------|--------------------------|---|
| Followed / measured my personal well-being and health, and its changes regularly (e.g. food diary, weight, blood pressure, welfare or activity bracelet) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Searched for reliable information to promote my personal health and well-being or sought information about diseases, their symptoms and treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Taken risk tests, symptom assessments, a health check or a written evaluation of my personal functional capacity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Asked health- or welfare-related advice from a professional | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

83. How have you been doing the following things during the past year? *If electronic services replaced making a visit or a call, please also estimate how many times. You can choose between the traditional (paper, visit or phone call) and the electronic service use (via mobile devices or computer).*

| | no | yes traditionally | yes electronically | electronic services replaced visit or call: how many times |
|--|--------------------------|--------------------------|--------------------------|--|
| Sought information on health or social services in my region | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Compared the price, queues for, or the quality of the services offered | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Made an application for social service or social assistance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Scheduled an appointment in a social or health care service | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Requested a renewal of a medical prescription | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Received a decision on a social service or social assistance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

84. How have you been doing the following things during the past year? *If electronic services replaced making a visit or a call, please also estimate how many times. You can choose between the traditional (paper, visit or phone call) and the electronic service use (via mobile devices or computer).*

| | no | yes traditionally | yes electronically | electronic services replaced visit or call: how many times |
|---|--------------------------|--------------------------|--------------------------|--|
| Viewed the patient/customer data recorded by professionals about me | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Made requests to correct errors I have personally noticed in my patient / customer data | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Received laboratory or other test results | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Received my personal treatment or service plan | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

85. How have you been doing the following things during the past year? *If electronic services replaced making a visit or a call, please also estimate how many times. You can choose between the traditional (paper, visit or phone call) and the electronic service use (via mobile devices or computer).*

| | no | yes traditionally | yes electronically | electronic services replaced visit or call: how many times |
|--|--------------------------|--------------------------|--------------------------|--|
| Disclosed my personal measurements or other information to professionals related to the customer relationship | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Received advice or guidance from health care or social welfare professionals, e.g., based on the test results or the monitoring data I provided them | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Had an appointment with a health or social care professional | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Participated in peer support groups or other groups focused on specific customer groups | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Used services enhancing the safety of living at home (these have typically included monitoring visits, electronically e.g., a security bracelet) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Responded to social welfare or health care customer feedback surveys or given informal feedback | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Made a living will (an expression of the will for my own treatment and care) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

86. Have you taken care of any social and health care issues on behalf of another person (e.g. next of kin, dependant) in the past year?

- I have not
- yes, traditionally (on paper / letter, visit or call)
- yes, electronically. How many times were you able to avoid having to call or visit social and health care services thanks to the e-services? _____ times

87. What do you perceive as the most essential benefits of electronic social and health care services? Electronic services

| | completely agree | partially agree | neither agree nor disagree | partially disagree | completely disagree |
|---|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| helping people self-manage their health / well-being | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| helping people assess the risks / need for services related to health / well-being | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| supporting finding and choosing services most suitable for the person | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| helping people promote the health / well-being of their next of kin/ dependant | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| providing useful reminders (e.g. The time of reception, laboratory tests, renewing prescriptions, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| facilitating getting appropriate services regardless of time and place | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| facilitating people's participation in the treatment of their health / well-being issue in cooperation with professionals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| helping the maintenance of the security of customer and patient data | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| helping the adaptation of services to different customer groups | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| supporting collaboration and information flow between the patient / customer and the social and health personnel in charge of the person's treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| helping patients / customers in following where their health and customer data have been processed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| saving time or money that making transactions In person would take (travel costs, working hours) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| enabling shorter and more efficient care (e.g. avoiding overlap of examinations and data collection, collecting preliminary data electronically already before the appointment) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other please specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

88. How important is it for you to use the following social welfare and health care services electronically in the future?

| | completely useless | quite useless | not useless and not important | quite important | very important |
|---|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|
| e-information and e-testing that support self-care and service need assessment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Online services supporting searching for, selecting and booking suitable services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Possibility to read my personal patient / customer data | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Online services that support interaction with professionals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Possibility to express personal will (e.g. living will and refusal to allow the use of patient data) and services for giving feedback | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other please specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

89. What factors make it impossible/difficult for you to use the online social and health care services?

| | completely agree | partially agree | neither agree nor disagree | partially disagree | completely disagree |
|--|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| I do not have a computer and internet connection of my own | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I do not have sufficient technical skills to use the e-services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Data connections are poor in my area | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Electronic services are difficult to use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Electronic services are not available in my native language | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have not received support for using the online services of social and health care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I cannot get help anywhere in the event of a technical problem | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Electronic services do not interest me | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I do not benefit from using the e-services in any way | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I think the electronic services are unnecessary as I can contact professionals by telephone during their telephone hours | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I do not think I will receive good care unless I meet the health care professional face to face | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Electronic services make it slower to access social or health services and delay the care or service process | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Face-to-face encounters cannot be replaced by electronic contacts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The non-medical parts of my care do not receive sufficient attention unless I meet the caregiver face to face | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I cannot be sure that errors, such as those in my medication, will be avoided | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I am concerned about data security when it comes to my personal details | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I do not trust electronic service providers (the possibility of being cheated) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The terms of use are vague and too long ("I have read and agree to these terms") | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I do not trust that my personal information is kept strictly confidential in anonymous contacts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The services I need are not available electronically | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| It is hard to find electronic services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The electronic services are not accessible to me e.g. due to my visual impairment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I cannot carry out transactions electronically on behalf of a third party, although it would be necessary | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other please specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

The following five sections related to accidents concern 1) home accidents, 2) accidents during exercise, 3) occupational accidents, 4) traffic accidents and 5) other leisure-time accidents. These questions focus on how the accident occurred, what kind of injuries it caused and what kind of treatment the injuries required.

HOME ACCIDENTS

90. Have you had an accident at home over the past 12 months? An accident at home is an accident that occurs at home, in the home yard area, at the holiday home, summer cottage or other accommodation and which causes injuries due to, for example, falling down, sustaining a burn or becoming injured by a sharp object such as a knife or broken glass.

- no (go to question 97. to the 'Accidents during exercise' section)
 yes, how many times in total over the past 12 months? _____ times

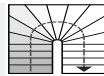

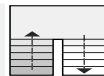
91. How did the accident at home occur? If you have had several accidents at home over the past 12 months, please describe the three most recent. Please enter your answer for each accident at home separately by selecting a suitable option for each accident (Accident 1, Accident 2, Accident 3). Please select the option that best describes your situation for each accident at home.

| | Accident 1 | Accident 2 | Accident 3 |
|---|--------------------------|--------------------------|--------------------------|
| tripping, falling down, slipping or falling from a low height (under 1 m) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| falling from higher than 1 m | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| collision with a person or object | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| poisoning or exposure to other harmful agent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| electric shock | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| abnormal temperatures; burn (fire, combustion gas, etc.), frostbite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| injury caused by a sharp object | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other cause, please specify: _____ | | | |

92. Did your being in a hurry, tired or careless contribute to the accident at home?

| | Accident 1 | Accident 2 | Accident 3 |
|-----|--------------------------|--------------------------|--------------------------|
| no | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

93. In what kind of place or space did the accident at home occur? Please select an option that best describes your situation for each accident at home.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| room (living room, bedroom, children's room, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| kitchen | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| toilet, bathroom or sauna facilities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yard area, balcony, terrace | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| garage, hobby room | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| basement, attic, storage room or shed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| rotating indoor stairs  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| straight indoor stairs the length of the entire flight  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| indoor stairs in two parts with a landing  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other place, please specify: _____ | | | |

94. What was the most serious injury caused by an accident at home?

Please select an option that best describes your situation for each accident at home.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| no injuries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| bruises, contusions or wounds | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| sprain, strain or dislocation or muscle injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| fracture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| concussion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| head area injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| eye injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| dental injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| burn injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| frost injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| psychological trauma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other injury, please specify: _____ | | | |

95. What kind of treatment did you receive? Please select an option that best describes your situation for each accident at home.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| self treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| treatment by a nurse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| treatment by a doctor in emergency or acute care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| hospital care at the ward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| hospital care (surgery) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

96. Were you under the influence of alcohol, pharmaceuticals affecting your functioning or drugs when the accident occurred?

| | Accident 1 | Accident 2 | Accident 3 |
|-----|--------------------------|--------------------------|--------------------------|
| no | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

ACCIDENTS DURING EXERCISE

97. Have you had an exercise injury over the past 12 months?

- no (go to question 106. to the 'Traffic accidents' section)
 yes, how many times in total over the past 12 months? _____ number

98. In what context did the exercise injury occur? If you have had several exercise injuries over the past 12 months, please describe the three most recent. Please enter your answer for each injury separately by ticking the corresponding column (Accident 1, Accident 2 or Accident 3).

| | Accident 1 | Accident 2 | Accident 3 |
|-----------------------------|--------------------------|--------------------------|--------------------------|
| during free time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| at an educational institute | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| during exercise at work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

99. How did the exercise injury occur?

Please select an option that best describes your situation for each exercise injury.

| | Accident 1 | Accident 2 | Accident 3 |
|---|--------------------------|--------------------------|--------------------------|
| tripping, falling down, slipping or falling from a low height (under 1 m) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| falling from higher than 1 m | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| collision with a person or object | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| injury caused by game or sport equipment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| temperature (hot, cold) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| performance error | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| previous injury, overstraining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| if the injury occurred in some other way, please specify: _____ | | | |

100. Did your being in a hurry, tired or careless contribute to the accident?

| | Accident 1 | Accident 2 | Accident 3 |
|-----|--------------------------|--------------------------|--------------------------|
| no | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

101. In what kind of place or space did the exercise injury occur?

Please select an option that best describes your situation for each exercise injury.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| sports or gym hall, hall for ball games | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ice hall, ice field or rink | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| sports field | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| pedestrian and bicycle way, zebra crossing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| running track, cross-country track | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| forest, field, shoreline or other cross-country or natural environment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| sea, lake, river or other corresponding body of water | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yard or parking area, park, market etc. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| workplace sports facility | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| home or home yard, yard at the holiday home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| on a trip abroad | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other place or space, please specify: _____ | | | |

102. Which sport was in question when the exercise injury occurred?

Please select an option that best describes your situation for each exercise injury.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| football | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| floorball | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| volleyball | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ice hockey, bandy, ringette | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| skating, rollerblading | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| fitness-enhancing physical activity (jogging, walking, Nordic walking, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| gym workout, weight lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| backpacking, hiking, orienteering | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| skiing, down-hill skiing, snowboarding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| swimming or other water sport (rowing, canoeing, stand-up-paddling) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| bicycling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| motor sports (including water skiing, water scooter) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| martial arts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| animal sports (e.g. riding, dog races, combined driving) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| golf, bowling, pétanque, billiards (Sports that use a solid ball) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| trampoline | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other sport, please specify: _____ | | | |

103. What was the most serious injury caused by the exercise injury?

Please select an option that best describes your situation for each exercise injury.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| no injuries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| bruises, contusions or wounds | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| sprain, strain or dislocation or muscle injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| fracture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| concussion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| head area injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| eye injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| dental injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| burn injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| frost injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| psychological trauma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other injury, please specify: _____ | | | |

104. What kind of treatment did you receive?

Please select an option that best describes your situation for each exercise injury.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| self treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| treatment by a nurse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| treatment by a doctor in emergency or acute care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| hospital care at the ward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| hospital care (surgery) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

105. Were you under the influence of alcohol, pharmaceuticals affecting your functioning or drugs when the accident occurred?

| | Accident 1 | Accident 2 | Accident 3 |
|-----|--------------------------|--------------------------|--------------------------|
| no | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

TRAFFIC ACCIDENTS

106. Have you been in a traffic accident over the past 12 months? A traffic accident refers to an accident such as a collision or running off the road involving a car or some other vehicle, and to vulnerable road user traffic accidents, which involve pedestrians or bicycle riders.

- no (go to question 114. to the 'Occupational accidents' section)
- yes, how many times in total over the past 12 months? _____ number

107. How did the traffic accident occur? If you have been in several traffic accidents over the past 12 months, please describe the three most recent. Please enter your answer for each traffic accident separately by selecting a suitable option for each accident (Accident 1, Accident 2, Accident 3). Please select the option that best describes your situation for each traffic accident.

| | Accident 1 | Accident 2 | Accident 3 |
|---|--------------------------|--------------------------|--------------------------|
| a collision with a (moving) motor vehicle (including being run over or colliding with a car as a pedestrian or bicycle rider) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| a single accident with no other participants (e.g. running off the road, crashing to a solid object, falling down as a pedestrian or bicycle rider) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| collision with a parked vehicle | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| animal accident | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other cause, please specify: _____ | | | |

108. When the accident occurred, what was your role in the traffic:

Please select an option that best describes your situation for each traffic accident.

| | Accident 1 | Accident 2 | Accident 3 |
|------------------------------|--------------------------|--------------------------|--------------------------|
| pedestrian | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| bicycle rider | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| car driver | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| motorcycle or moped driver | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| driver of some other vehicle | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

109. Did your being in a hurry, tired or careless contribute to the traffic accident?

Please select an option that best describes your situation for each traffic accident.

| | Accident 1 | Accident 2 | Accident 3 |
|-----|--------------------------|--------------------------|--------------------------|
| no | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

110. In what kind of place or space did the traffic accident occur?

Please select an option that best describes your situation for each traffic accident.

| | Accident 1 | Accident 2 | Accident 3 |
|---|--------------------------|--------------------------|--------------------------|
| pavement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| walkway or bicycle path | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| zebra crossing, crossing of a bicycle path and road | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| street or road in a residential area | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| road outside a residential area | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| motorway | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| other, e.g. public parking area | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yard of a block of flats or detached house | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| country, forest or field area | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| sea, lake, river or other similar body of water | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other place, please specify: _____ | | | |

111. What was the most serious injury you sustained by the traffic accident?

Please select an option that best describes your situation for each traffic accident.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| no injuries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| bruises, contusions or wounds | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| sprain, strain or dislocation or muscle injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| fracture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| concussion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| head area injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| eye injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| dental injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| burn injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| frost injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| psychological trauma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other injury, please specify: _____ | | | |

112. What kind of treatment did you receive?

Please select an option that best describes your situation for each traffic accident.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| self treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| treatment by a nurse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| treatment by a doctor in emergency or acute care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| hospital care at the ward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| hospital care (surgery) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

113. Were you under the influence of alcohol, pharmaceuticals affecting your functioning or drugs when the traffic accident occurred?

| | Accident 1 | Accident 2 | Accident 3 |
|-----|--------------------------|--------------------------|--------------------------|
| no | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

OCCUPATIONAL ACCIDENTS

114. Have you been in an occupational accident over the past 12 months? Please also take in account accidents that occurred on your way to or from work, in practical training, in a study environment, volunteer work or situations comparable to them

- no (go to question 122. to the 'Other leisure-time accidents' section)
 yes, how many times in total over the past 12 months? _____ times

115. How did the occupational accident occur? If you have been in several occupational accidents over the past 12 months, please describe the three most recent. Please enter your answer for each occupational accident separately by selecting a suitable option for each accident (Accident 1, Accident 2, Accident 3). Please select the option that best describes your situation for each accident.

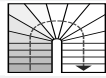

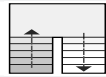
| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| collapse of structures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| falling down, slipping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| falling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| falling object | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| becoming entangled, being crushed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| being hurt by a sharp object | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| sudden movement, lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other cause, please specify: _____ | | | |

116. Did your being in a hurry, tired or careless contribute to the occupational accident?

| | Accident 1 | Accident 2 | Accident 3 |
|-----|--------------------------|--------------------------|--------------------------|
| no | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

117. In what kind of place or space did the occupational accident occur?

Please select an option that best describes your situation for each occupational accident.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| at work, outside the home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| on the way to or from work, on a business trip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| when working at home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| rotating indoor stairs  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| straight indoor stairs the length of the entire flight  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| indoor stairs in two parts with a landing  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If other, please specify: _____ | | | |

118. What was the most serious injury caused by the occupational accident?

Please select an option that best describes your situation for each occupational accident.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| no injuries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| bruises, contusions or wounds | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| sprain, strain or dislocation or muscle injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| fracture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| concussion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| head area injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| eye injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| dental injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| burn injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| frost injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| psychological trauma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other injury, please specify: _____ | | | |

119. What kind of treatment did you receive for your injuries?

Please select an option that best describes your situation for each occupational accident.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| self treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| treatment by a nurse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| treatment by a doctor in emergency or acute care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| hospital care at the ward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| hospital care (surgery) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

120. Var man medveten om den riskfaktor som orsakade arbetsolyckan?

| | Accident 1 | Accident 2 | Accident 3 |
|-----|--------------------------|--------------------------|--------------------------|
| yes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| no | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

121. Are you able to influence occupational safety issues at your workplace?

- yes
 no

OTHER LEISURE-TIME ACCIDENTS

122. Have you been in any other kind of leisure time accidents over the past 12 months?

Other leisure time accidents refer to injuries sustained elsewhere than via exercise injuries, occupational accidents, accidents at home or traffic accidents such as slipping on a shopping trip, becoming injured when doing voluntary work or when camping, boating or when in a camping van.

- no (go to question 127, section 'Absences from work due to illness')
 yes, how many times in total over the past 12 months? _____ times

123. How did the leisure time accident occur? If you have been in several leisure time accidents over the past 12 months, please describe the three most recent. Please enter your answer for each leisure time accident separately by selecting a suitable option for each accident (Accident 1, Accident 2 or Accident 3).

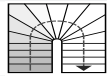

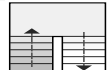
| | Accident 1 | Accident 2 | Accident 3 |
|---|--------------------------|--------------------------|--------------------------|
| tripping, falling down, slipping or falling from a low height (under 1 m) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| falling from higher than 1 m | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| collision with a person or object | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| poisoning or exposure to other harmful agent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| electric shock | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| abnormal temperatures; burn (fire, combustion gas, etc.), frostbite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| injury caused by a sharp object | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other cause, please specify: _____ | | | |

124. Did your being in a hurry, tired or careless contribute to the leisure time accident?

| | Accident 1 | Accident 2 | Accident 3 |
|-----|--------------------------|--------------------------|--------------------------|
| no | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

125. In what kind of place or space did the leisure time accident occur?

Please select an option that best describes your situation for each accident.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| pedestrian and cycle paths | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| driveway | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yard or parking area for a public building | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| yard or parking area for a residential building | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| countryside, e.g. forest or field area | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| outdoors elsewhere, e.g. at a bus stop, park or market place | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| inside a public building | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| rotating indoor stairs  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| straight indoor stairs the length of the entire flight  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| indoor stairs in two parts with a landing  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If other, please specify: _____ | | | |

126. What was the most serious injury caused by the leisure time accident?

Please select an option that best describes your situation for each accident.

| | Accident 1 | Accident 2 | Accident 3 |
|--|--------------------------|--------------------------|--------------------------|
| no injuries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| bruises, contusions or wounds | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| sprain, strain or dislocation or muscle injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| fracture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| concussion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| head area injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| eye injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| dental injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| burn injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| frost injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| psychological trauma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If some other injury, please specify: _____ | | | |

ABSENCES FROM WORK DUE TO ILLNESS

The following questions concern the treatment you received for injuries due to accidents or violence, as well as your absences from work due to such incidents. If you have had several accidents during the past 12 months, please specify **the three most recent ones**. Please specify the number of days for each accident in the appropriate field (Accident 1, Accident 2 or Accident 3).

127. How many days did you have to stay in hospital because of your injuries?

| | Accident 1 | Accident 2 | Accident 3 |
|------------------------------|------------|------------|------------|
| Home accidents | _____ days | _____ days | _____ days |
| Accidents during exercise | _____ days | _____ days | _____ days |
| Traffic accidents | _____ days | _____ days | _____ days |
| Occupational accidents | _____ days | _____ days | _____ days |
| Other leisure-time accidents | _____ days | _____ days | _____ days |
| Violence | _____ days | _____ days | _____ days |

128. For how many days was it difficult or impossible for you to cope with your regular daily chores and activities because of your injuries? (in addition to possible days in hospital)

| | Accident 1 | Accident 2 | Accident 3 |
|------------------------------|------------|------------|------------|
| Home accidents | _____ days | _____ days | _____ days |
| Accidents during exercise | _____ days | _____ days | _____ days |
| Traffic accidents | _____ days | _____ days | _____ days |
| Occupational accidents | _____ days | _____ days | _____ days |
| Other leisure-time accidents | _____ days | _____ days | _____ days |
| Violence | _____ days | _____ days | _____ days |

129. How many days did you have to be absent from work due to your injuries (including days in hospital)?

| | Accident 1 | Accident 2 | Accident 3 |
|------------------------------|------------|------------|------------|
| Home accidents | _____ days | _____ days | _____ days |
| Accidents during exercise | _____ days | _____ days | _____ days |
| Traffic accidents | _____ days | _____ days | _____ days |
| Occupational accidents | _____ days | _____ days | _____ days |
| Other leisure-time accidents | _____ days | _____ days | _____ days |
| Violence | _____ days | _____ days | _____ days |

VIOLENCE

130. Has anyone demanded money or property from you by threats or extortion over the past 12 months?

You may choose more than one option.

- no one
- unknown person or casual acquaintance
- present spouse, cohabitant or partner
- other person well known to you (other family member, ex-spouse, friend, close acquaintance, colleague)

131. If you have been a victim of violence over the past 12 months, did you seek help from:

You may choose more than one option.

- services offered by various organisations (e.g. Rape Crisis Centre Tukinainen, Tyttöjen Talo, Victim Support Finland, Monika Multicultural Women's Association, shelters, crisis centres, municipal sexual therapists or corresponding)
- health care or social welfare services (e.g. hospital or health centre emergency clinic)
- I have not been a victim of violence over the past 12 months. *You can skip the next question.*

132. How were you treated when you sought the above mentioned services?

You may choose more than one option.

- appropriately and expertly
- helpfully and sympathetically
- cruelly
- indifferently
- in some other manner _____

FOR MEN, THIS CONCLUDES THE SURVEY.

THANK YOU FOR YOUR TIME!

**Please remember to remove the covering letter before sending the questionnaire.
You can see the results of the survey at www.thl.fi/ath**

The following questions only apply to women.

133. How many children have you borne?

- none
- in total _____ childbirths

134. Have you had any abortions?

- no
- yes _____ abortions

135. Have you had miscarriages or ectopic pregnancies?

- no
- yes _____ pregnancies

THANK YOU FOR YOUR TIME!

**Please remember to remove the covering letter before sending the questionnaire.
You can see the results of the survey at www.thl.fi/ath**