

## 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](http://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:

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

#### 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](mailto:ath-info@thl.fi)

[www.thl.fi/ath/osallistuvalla](http://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

### 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"/>

**8. 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"/>

**HEALTH**

**9. How tall are you?** \_\_\_\_\_ cm, *please round to nearest centimeter*

**10. How much do you weigh when wearing light clothing?** \_\_\_\_\_ kg, *please round to nearest kilogram*

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

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

**12. Do you have any longstanding illness or health problem?**

- yes
- no

**13. 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 15*)

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

- yes
- no

**15. 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

**16. 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"/>
(cerebral) stroke	<input type="checkbox"/>
high blood cholesterol	<input type="checkbox"/>
coronary thrombosis, myocardial infarction	<input type="checkbox"/>
coronary disease, angina pectoris (=chest pain under physical stress)	<input type="checkbox"/>
arthrosis of the back, sciatica, lower back pain or other back condition	<input type="checkbox"/>
chronic bronchitis, emphysema	<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"/>

**17. 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.

**18. 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"/>					
in such a low mood that nothing could cheer you up	<input type="checkbox"/>					
calm and peaceful	<input type="checkbox"/>					
downhearted and sad	<input type="checkbox"/>					
happy	<input type="checkbox"/>					

**19. Do you ever feel lonely:**

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

**20. 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

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

- no
- yes

**FUNCTIONAL AND WORKING CAPACITY**

**22. 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"/>				
by phone	<input type="checkbox"/>				
over the Internet (e-mail, chat, Skype, Facebook, etc.) or by letter	<input type="checkbox"/>				





**23. 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

**24. 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 neigh- bour	other person close to you	no one
who do you believe truly cares about you, whatever may happen?	<input type="checkbox"/>	<input type="checkbox"/>					
who will provide practical help when you need it?	<input type="checkbox"/>	<input type="checkbox"/>					

**25. 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 27)*
- yes, my spouse
- yes, my child or grandchild
- yes, my own or my spouse's parents
- yes, some other person, whom? \_\_\_\_\_

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

- no
- yes

**27. 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"/>





**28. 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"/>
walk up one flight of stairs without stopping to rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
move about outdoors in summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
move about outdoors in winter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
use public transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**29. Can you usually perform the following everyday chores and actions?**

	yes, no problem	yes, with some difficulty	yes, but with great difficulty	no, I cannot
light housework (vacuuming, washing dishes, making beds, doing laundry, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
minor repairs (replacing a light bulb or a smoke alarm battery, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
day-to-day financial transactions (paying bills, withdrawing cash, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
shopping for food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**30. The following questions concern memory, learning and concentration:**

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





**31. If your functional capacity is impaired, do you need and do you get help for your everyday actions?**

- I do not need help and do not get it
- I would need help but do not get it
- I get help, but not enough
- I get enough help
- I get more help than I need

**32. 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"/>					
mentally	<input type="checkbox"/>					

**33. 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"/>				
I feel I am neglecting domestic issues because of my work	<input type="checkbox"/>				
I sometimes neglect my family when I am wholly absorbed in my work	<input type="checkbox"/>				
I often find it difficult to concentrate on my work because of domestic issues	<input type="checkbox"/>				
I have more energy to be with the children when I also go to work	<input type="checkbox"/>				

**34. 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"/>											

**35. 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"/>					
considering the mental demands of your work	<input type="checkbox"/>					





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

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

**37. 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 (38-40 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.*

**38. 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

**39. 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

**40. 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





**41. 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"/>

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

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

**43. 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



**44. 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"/>

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

On average \_\_\_\_\_ hours

**46. Do you feel that you get enough sleep?**

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

**47. Have you ever smoked?**

- no, *(if you have not smoked, proceed to question 50)*
- yes

**48. 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

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

- yes, daily
- occasionally
- not at all

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

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



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

- no (*proceed to question 56*)
- yes

**52. 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

**53. 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

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

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

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

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

**55. 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.**

	<b>over the past 7 days</b>
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 <i>(only sold in Alko shops, alcohol content over 4.7%)</i>	_____ bottles (à 33 cl)
wine	_____ glass (1 glass = appr. 12 cl)
spirits or other strong drinks	_____ restaurant portions (appr. 4 cl)

**56. 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.

**57. 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

**58. 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"/>

**59. Do you use the following protective equipment?**

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





**60. 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"/>

**61. 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

**62. 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





## SERVICES

### 63. 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"/>

### 64. 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"/>
treatment and care services available at home (e.g. home care, meal and other support services, rehabilitation services, home alteration work)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other services for the elderly (e.g. sheltered housing, residential home, family care)	<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"/>
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"/>

### 65. 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"/>				
high customer fees	<input type="checkbox"/>				





**66. 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"/>				
high customer fees	<input type="checkbox"/>				

**67. 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"/>				
I saw a nurse	<input type="checkbox"/>				

**68. 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
<b>By phone</b>					
with a doctor	<input type="checkbox"/>				
with a nurse	<input type="checkbox"/>				
with another health care professional	<input type="checkbox"/>				
with a social worker or social instructor	<input type="checkbox"/>				
<b>Via electronic services</b>					
with a doctor	<input type="checkbox"/>				
with a nurse	<input type="checkbox"/>				
with another health care professional	<input type="checkbox"/>				
with a social worker or social instructor	<input type="checkbox"/>				





**69. 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

**70. 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

**71. 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"/>				
I was examined without undue delay	<input type="checkbox"/>				
the end result of the service corresponded to the need	<input type="checkbox"/>				
my problem was handled smoothly and information run between professionals	<input type="checkbox"/>				

**72. 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"/>				
the surgery of a dental assistant or dental hygienist	<input type="checkbox"/>				

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

- no
- yes





**74. 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"/>

**75. 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
colorectal cancer screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>

**76. 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"/>

**77. 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 79*)





**78. 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"/>				
the end result of the service corresponded to the need	<input type="checkbox"/>				
my problem was handled smoothly and information run between professionals	<input type="checkbox"/>				

**QUALITY OF LIFE**

When answering questions number (79-81), please consider the past two weeks.

**79. How would you rate your quality of life?**

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

**80. 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"/>

**81. 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"/>				
have you enough money to meet your needs?	<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

**82. 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 89. to the 'Accidents during exercise' section)  
 yes, how many times in total over the past 12 months? \_\_\_\_\_ times

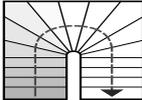
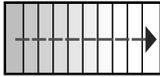
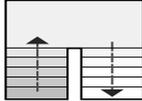
**83. How did the accident at home occur? If you have had several accidents at home over the past 12 months, please describe the three most recent.** *Please enter your answer for each accident at home separately by selecting a suitable option for each accident (Accident 1, Accident 2, Accident 3). Please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

**84. 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"/>

**85. 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: _____			

**86. 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: _____			



**87. 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"/>

**88. 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**

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

- no (*go to question 98. to the 'Traffic accidents' section*)
- yes, how many times in total over the past 12 months? \_\_\_\_\_ number

**90. 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"/>



**91. 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: _____			

**92. 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"/>

**93. 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: _____			



**94. 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:	_____	_____	_____

**95. 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:	_____	_____	_____



**96. 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"/>

**97. 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

**98. 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 106. to the 'Occupational accidents' section)
- yes, how many times in total over the past 12 months? \_\_\_\_\_ number

**99. 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:	_____	_____	_____



**100. 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"/>

**101. 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"/>

**102. 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:	_____	_____	_____



**103. 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:	_____	_____	_____

**104. 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"/>

**105. 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

**106. 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 114. to the 'Other leisure-time accidents' section)
- yes, how many times in total over the past 12 months? \_\_\_\_\_ times

**107. 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.*

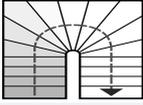
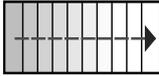
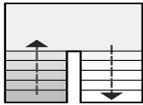
	Accident 1	Accident 2	Accident 3
collapse of structures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
falling down, slipping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
falling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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:	_____	_____	_____

**108. 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"/>



**109. 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:		_____	_____	_____

**110. 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:	_____	_____	_____



**111. 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"/>

**112. Was the danger that caused the occupational accident known prior to the accident?**

	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"/>

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

- yes
- no

**OTHER LEISURE-TIME ACCIDENTS**

**114. 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 119, section 'Absences from work due to illness')
- yes, how many times in total over the past 12 months? \_\_\_\_\_ times





**115. 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:	_____	_____	_____

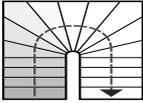
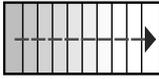
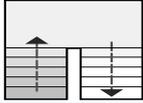
**116. Did your being in a hurry, tired or careless contribute to the leisure time accident?**

	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"/>





**117. 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: _____			

**118. 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).

### 119. 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

### 120. 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

### 121. 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

**122. 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)

**123. 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.*

**124. 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: \_\_\_\_\_

**125. Did you fill in this form alone, or did someone assist you?**

- I filled it in alone
- I filled it in together with my spouse
- I filled it in together with another family member
- I filled it in together with a nurse or home care employee
- I was assisted by someone else. Please specify? \_\_\_\_\_

**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](http://www.thl.fi/ath)**

