

## REGIONAL HEALTH AND WELL-BEING STUDY, ATH 2014

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/2014a](http://www.thl.fi/ath/2014a). 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

## BACKGROUND INFORMATION

Tick the correct alternative or write the information number required in the space given

### 1. Gender

- male
- female

2. Year of birth 19 \_\_\_\_\_

### 3. Marital status

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

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

Including primary and comprehensive school.

\_\_\_\_\_ years

### 5. What is your form of accommodation at the moment:

- A dwelling owned by you or by a member of the family living in that dwelling
- A rental dwelling (owned by a local authority or a community interest company)
- Sheltered accommodation, rehabilitation home or home for elderly people?
- Other, please specify: \_\_\_\_\_

### 6. How many of the people living in your household are (do not include yourself):

	none	1 person	2 persons	3 persons	4 persons	5+ persons
under the age of 3	<input type="checkbox"/>					
aged 3 to 6	<input type="checkbox"/>					
aged 7 to 17	<input type="checkbox"/>					
aged 18 to 24	<input type="checkbox"/>					
aged 25 to 64	<input type="checkbox"/>					
aged 65 to 74	<input type="checkbox"/>					
aged 75+	<input type="checkbox"/>					

### 7. Currently, are you pregnant or is your spouse/partner pregnant?

- no
- yes

#### For further information about the study, please contact

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**8. Are you currently mainly:**

- in full-time work
- in part-time work or on part-time pension
- on old-age pension
- on disability pension or a recipient of rehabilitation allowance
- unemployed or laid off, length of current period in months: \_\_\_\_\_
- on family leave or a stay-at-home parent
- student
- other? \_\_\_\_\_

**9. What is/was your latest employment status/type of work?**

- wage and salary earner
  - private enterprise
  - public sector, state or state agency
  - public sector, municipality or municipal agency
- farmer
- other entrepreneur
- self-employed or freelancer
- unpaid family worker
- I have never worked full-time in any profession
- some other, what? \_\_\_\_\_

**LIVING CONDITIONS, WORKING CONDITIONS AND WELL-BEING**

**10. A household may have different sources of income, and more than one of the people living in it may have an income. Considering the total income of your household, how difficult or easy is it to cover your costs:**

- very difficult
- difficult
- fairly difficult
- fairly easy
- easy
- very easy

**11. 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"/>

**12. 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 footpaths 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 services (e.g. shops)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
environmental untidiness	<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"/>
buildings in poor condition or unattractive housing district	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
threat of dangerous wild animals/ predators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**13. How satisfied are you with the following characteristics of your present dwelling:**

	very satisfied	fairly satisfied	neither satisfied nor dissatisfied	fairly dissatisfied	very dissatisfied
safety of the area/ neighbourhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
housing costs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**14. Do you have an Internet connection at your household?**

- no
- yes

**15. Do you use the Internet for the following?:**

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

**16. 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?**

	almost daily	1-2 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"/>				

**17. 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 -> *You can skip the three following numbered questions*  
 yes, actively  
 yes, occasionally

**18. During the last 12 months, how often have you taken part in activities organised by the following types of organisations, associations, or clubs?**

	never	less than once a month	1-3 times a month	1-2 times a month	3 times a week or more often
sports club	<input type="checkbox"/>				
culture association or organisation	<input type="checkbox"/>				
political or trade association (e.g. trade union)	<input type="checkbox"/>				
organisation for the unemployed	<input type="checkbox"/>				
parish	<input type="checkbox"/>				
organisation for older people (e.g. for pensions or front veterans, other old-age care organisations)	<input type="checkbox"/>				
child, youth or family organisation (e.g. Mannerheim League for Child Welfare)	<input type="checkbox"/>				
public health or patient organisation (e.g. Finnish Red Cross, Finnish Diabetes Association, Finnish Heart Association, Allergy and Asthma Federation)	<input type="checkbox"/>				
mental health or substance abuse organisation (e.g. Finnish Association for Mental Health, A Clinic Foundation)	<input type="checkbox"/>				
disability organisation (e.g. Finnish Association of People with Mobility Disabilities, Finnish Central Association of the Visually Impaired)	<input type="checkbox"/>				
organisation for care giving relatives (e.g. Association of Care Giving Relatives and Friends, National Family Association Promoting Mental Health)	<input type="checkbox"/>				
informal activity group	<input type="checkbox"/>				
some other	<input type="checkbox"/>				

**19. If you did take part in the activities of an organisation during the last 12 months, how did you first get information about the activities? *You can choose several options.***

- the internet (e.g. the organisation's home page or social media, such as Facebook, discussion forums)  
 magazines published by organisations, local newspaper or other media  
 relative or friend  
 health care or social welfare unit, employment office (e.g. recommended by doctor, nurse or social worker)  
 otherwise, how? \_\_\_\_\_

**20. During the last 12 months, why did you take part in an organisation's activities?**

*Choose the most important reasons.*

- I want to help other people  
 I want to learn new things or get more information  
 I want to meet new people  
 I want to belong to a group  
 I want to take part in my child's/children's hobbies  
 I want to meet other people in the same situation and get peer support  
 I want to influence social issues  
 Voluntary work is useful for my studies and/or work  
 I get help/support in my life situation  
 I get something meaningful to do  
 Other reason, what? \_\_\_\_\_

**21. Why haven't you taken part in any organisation's activities? If you have taken part in the activities of some organisation, move to the next question.**

*You can choose several options.*

- I feel no need for it  
 The kinds of activities I am interested in are not organised in my neighbourhood  
 I do not know enough about the organisations active in my neighbourhood  
 I do not have time  
 Poor means of transportation  
 I or someone close to me has poor health or functional capacity which prevents me from taking part  
 Other reason, what? \_\_\_\_\_

**22. 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"/>					
Who will provide practical help when you need it?	<input type="checkbox"/>	<input type="checkbox"/>					

**23. Have you yourself time over the past 12 months helped someone not belonging to your household in any of the following matters in your free? Whom?**

*You may choose more than one alternative on each line.*

	no, I have not	yes, my own or my spouse's parents	yes, my own or my spouse's grandparents	yes, my children or grandchildren	yes, other persons
child care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
house and garden work (cooking, cleaning, gardening, snow removal etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
shopping, banking and other similar matters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
health and hygiene (dressing, washing, medication, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mental support (listening or supporting in difficult times)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
financial support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**24. How often have you yourself helped someone who does not live in your household over the past 12 months? Please choose only one alternative on each line.**

	never	once or a few times in the year	once or twice a month	once or twice a week	every day or most days
my own or my spouse's parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
my own or my spouse's grandparents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
children or grandchildren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other persons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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 may choose more than one alternative on each line.**

- no, --> *You can move to the next question.*
- 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? \_\_\_\_\_

**26. Are you the official informal caregiver for this person (have you entered an agreement with the municipality)?**

- no
- yes

*The following questions are about your work.*

**27. 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"/>					

**28. How satisfied are you with your present work/were you with your most recent job?**

- extremely satisfied
- fairly satisfied
- neither satisfied nor dissatisfied
- fairly dissatisfied
- extremely dissatisfied
- I have never been in paid employment

**29. How many fixed-term employment relationships have you had over the past two (2) years?**

*Include all new fixed-term/temporary/time limited employment relationships and all continuations of old ones. A fixed-term employment relationship is one that has a fixed end date. .*

\_\_\_\_\_ in total

**30. Are the following statements about home and work accurate for you?**

*Please choose one alternative on each line.*

	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"/>				
I feel inadequacy as a parent	<input type="checkbox"/>				

**31. Did you vote in the most recent elections:**

	no	yes	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"/>

**32. How much do you trust the following parties or what they do?**

On each line, choose alternative that matches your opinion: (I do not trust at all --- I trust completely).

	I do not trust them at all			I trust them completely		
public health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
public social welfare (social services, social assistance, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
courts of law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
decision-making in your municipality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
people in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HEALTH**

**33. How tall are you?** \_\_\_\_\_ cm to the nearest centimetre.

**34. How much do you weigh when wearing light clothing?**

\_\_\_\_\_ kg to the nearest kilogramme.

**35. How would you describe your current state of health?:**

- good
- rather good
- moderate
- rather poor
- poor

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

	no	yes
high blood pressure, hypertension	<input type="checkbox"/>	<input type="checkbox"/>
(cerebral) stroke	<input type="checkbox"/>	<input type="checkbox"/>
high blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
coronary thrombosis, myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>
coronary disease, angina pectoris (=chest pain under physical strain)	<input type="checkbox"/>	<input type="checkbox"/>
cancer	<input type="checkbox"/>	<input type="checkbox"/>
rheumatoid arthritis or other inflammatory arthritis	<input type="checkbox"/>	<input type="checkbox"/>
arthrosis of the back, sciatica, lower back pain or other back condition	<input type="checkbox"/>	<input type="checkbox"/>
chronic bronchitis, emphysema	<input type="checkbox"/>	<input type="checkbox"/>
depression	<input type="checkbox"/>	<input type="checkbox"/>
other mental health problem	<input type="checkbox"/>	<input type="checkbox"/>
asthma	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>

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

	no	yes
fever (temperature over 38°C)	<input type="checkbox"/>	<input type="checkbox"/>
headache	<input type="checkbox"/>	<input type="checkbox"/>
cough	<input type="checkbox"/>	<input type="checkbox"/>
diarrhea (at least three times a day on at least one day)	<input type="checkbox"/>	<input type="checkbox"/>
vomiting	<input type="checkbox"/>	<input type="checkbox"/>
joint ache	<input type="checkbox"/>	<input type="checkbox"/>
back pain, back ache	<input type="checkbox"/>	<input type="checkbox"/>
toothache	<input type="checkbox"/>	<input type="checkbox"/>
chest pain under physical strain	<input type="checkbox"/>	<input type="checkbox"/>
insomnia	<input type="checkbox"/>	<input type="checkbox"/>
stomach pain	<input type="checkbox"/>	<input type="checkbox"/>
incontinence	<input type="checkbox"/>	<input type="checkbox"/>
tinnitus (ringing in the ears)	<input type="checkbox"/>	<input type="checkbox"/>

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

- no  
 yes

*The following questions aim to collect data for the purpose of preventing infectious diseases and improving the services for sexual and reproductive health.*

**39. During the last 12 months, how many different people you have had sexual intercourse with?**

persons \_\_\_\_\_

- none --> *You can skip the two following numbered questions*

**40. During the last 12 months, have you had sexual intercourse**

- with men  
 with women  
 with both men and woman

**41. Which contraceptive method(s) did you use in the most recent sexual intercourse (enter both the method you yourself used and the method your partner used)? *You can choose several options.***

- condom  
 oral contraceptive pill, vaginal ring or contraceptive implant  
 intrauterine device I  
 sterilisation  
 some other method (diaphragm, spermicide, etc.)  
 none, we are hoping for a child/planning a pregnancy  
 none for other reasons

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

*Please choose one alternative on each line.*

	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"/>

*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.*

**43. 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"/>					
so down in the dumps 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"/>					

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

- never  
 very rarely  
 sometimes  
 fairly often  
 all the time

**45. 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 doings )	<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.*

	no	yes
<b>46. Have you thought about suicide over the past 12 months?</b>	<input type="checkbox"/>	<input type="checkbox"/>

## FUNCTIONAL AND WORKING CAPACITY

47. Can you usually perform the following actions?

	yes, no problem	yes, with some dif- ficulty	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"/>
run a long distance (more than 500 m)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

48. 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? *A score of 0 would mean that you are completely unable to work at present.*

\_\_\_\_\_ score

49. 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"/>					

50. Do you think that, as far as your health is concerned, you could continue in your present occupation until the retirement age/you could have continued in your most recent occupation until the retirement age?

- no  
 probably not  
 probably yes  
 yes  
 I am retired

## FOOD

51. 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 butter-margarine mixture (e.g. Oivariini)	<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"/>

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

- yes  
 no  
 I am not employed and not studying

53. Where do you usually have lunch (between 10 a.m. and 3 p.m.) on weekdays?

- at home  
 at a restaurant, diner or fast-food place  
 in the canteen at my workplace or educational institution  
 I have a packed lunch  
 somewhere else than the above  
 I do not eat lunch

## BRUSHING YOUR TEETH

### 54. How often do you usually brush your teeth?

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

## EXERCISE

The following questions concern how you get exercise at work, on the way to work and in your free time. If you exercise in different ways at different times of the year, please circle the alternative that best describes your average situation.

### 55. 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.

### 56. 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

### 57. How many hours do you spend sitting on an average weekday? If you never sit, please enter 0.

	hours
at work	_____
sparetime	_____

### 58. How physically active are you during a week? Think about the past year (12 months).

Consider all regular weekly physical activity which lasts at least 10 minutes per session. Select all alternatives that correspond to your physical activity habits, and add the weekly amount of each type of activity (frequency per week, duration in hours and minutes). If you are not weekly engaged in any type of regular physical activity select alternative "hardly any regular weekly physical activity" and pass the other alternatives.

	days in a week	altogether hours and minutes in a week
<input type="checkbox"/> hardly any regular weekly physical activity		
<input type="checkbox"/> easy and peaceful aerobic type exercise (no perspiration or shortness of breath, for example light walking)	_____ days in a week	tot. _____ hours _____ minutes
<input type="checkbox"/> brisk and lively aerobic type exercise (some perspiration and shortness of breath, for example brisk walking)	_____ days in a week	tot. _____ hours _____ minutes
<input type="checkbox"/> vigorous and strenuous aerobic type exercise (profound perspiration and shortness of breath, for example jogging or running)	_____ days in a week	tot. _____ hours _____ minutes
<input type="checkbox"/> neuromuscular training (for example keep-fit circuit training or muscular strength training in a gym, and including exercises for the main muscle groups with 8-12 repetitions)	_____ days in a week	tot. _____ hours _____ minutes
<input type="checkbox"/> activity that requires or develops balance (= e.g. tai chi, dancing, games, balance exercises on, for example, one leg, uneven ground or on hands and knees)	_____ days in a week	tot. _____ hours _____ minutes

## SMOKING

### 59. Have you ever smoked?

- no (You can go to the next section)  
 yes

### 60. 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 \_\_\_\_\_

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

- yes, daily  
 occasionally  
 not at all

## ALCOHOL AND DRUGS

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

- no -> *You can skip the four following numbered questions*  
 yes

63. 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.

*Please choose the alternative that best fits your situation.*

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

64. 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 UNIT OF ALCOHOL IS EQUAL TO:  
 1 bottle (33 cl) of medium strength beer or cider, or  
 1 glass (12 cl) of usual mild wine, or  
 1 small glass (8 cl) of fortified wine, or  
 A standard drink (4 cl) of strong spirits

65. 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 medium 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%) = 6 units  
 0.5 l bottle of spirits = 13 units

66. 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.*

	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 <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	_____ restaurantportions (appr. 4 cl)

67. Have you used cannabis (hashish, marijuana) over the past 12 months?

- I have never used  
 no  
 yes

*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, casino games and Internet gambling such as online poker.*

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

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

## CHANGES OF LIFESTYLE

69. 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	nurse or occupational health nurse	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"/>

## SLEEP

70. How many hours do usually sleep during one night?

\_\_\_\_\_ hours on average

71. Do you feel that you get enough sleep?

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

## ACCIDENTS AND VIOLENCE

**72. Have you had any accident that required counselling or treatment by a health care professional? What were the circumstances of the accident and what kind of treatment did you get for your injuries?**  
*You can choose several options.*

	no	yes, home treatment	yes, treatment by a nurse	yes, treatment by a doctor	yes, treatment in a hospital
in working hours, outside the home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
in free time, indoors at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
in free time, in the yard/garden at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
in free time, while exercising outside the home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
in some other context _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**73. Has anyone behaved violently towards you over the past 12 months?**  
*You can choose several options.*

	no one	unknown person or casual acquaintance	present spouse, cohabitee 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, by letter, by e-mail or by text message	<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, crabbing hold, 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"/>	_____	_____	_____

**74. 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 crampons when walking outdoors in slippery conditions	<input type="checkbox"/>				

## SERVICES

**75. How many times over the past 12 months have you seen a doctor or nurse in a surgery or seen them at your home because of an illness you have or had (or because of pregnancy or childbirth)?**

*If you have not seen a doctor or nurse at all, please enter 0. This does not include any times when you have been admitted to a hospital as an inpatient.*

	I saw a doctor	I saw a nurse
in occupational health care	_____ times	_____ times
at a health centre	_____ times	_____ times
at a private health clinic	_____ times	_____ times
at a hospital outpatient clinic	_____ times	_____ times
on a house call by a doctor or nurse	_____ times	_____ times
elsewhere, please specify: _____	_____ times	_____ times

**76. Over the past 12 months, have you visited any of the following:**

	no	yes
a dentist at a health centre	<input type="checkbox"/>	<input type="checkbox"/>
a dentist in private practice	<input type="checkbox"/>	<input type="checkbox"/>
other dentist (university, hospital, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
dental technician	<input type="checkbox"/>	<input type="checkbox"/>
the surgery of a dental assistant or dental hygienist	<input type="checkbox"/>	<input type="checkbox"/>

**77. Over the past 12 months, have you visited any services because of mental health problems or drug abuse problems?**

no, --> *You can move to the next question.*

<i>If yes, you may choose more than one alternative</i>	yes, because of mental health problems	yes, because of drug abuse problems
health centre	<input type="checkbox"/>	<input type="checkbox"/>
occupational health care	<input type="checkbox"/>	<input type="checkbox"/>
student health care	<input type="checkbox"/>	<input type="checkbox"/>
mental health clinic or psychiatry outpatient clinic	<input type="checkbox"/>	<input type="checkbox"/>
A-clinic	<input type="checkbox"/>	<input type="checkbox"/>
private surgery (doctor, psychologist, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
psychiatric hospital	<input type="checkbox"/>	<input type="checkbox"/>
other hospital	<input type="checkbox"/>	<input type="checkbox"/>
detoxification	<input type="checkbox"/>	<input type="checkbox"/>
other, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

**78. Have you regularly participated in a group for promoting your health and well-being over the past 12 months? Individual one-off lectures or discussions do not count**

no, --> *You can move to the next question*

	yes, it helped	yes, it did not help
dieting or weight control group or course, or other group aiming at changes in dietary and exercise habits	<input type="checkbox"/>	<input type="checkbox"/>
neck or back exercise group	<input type="checkbox"/>	<input type="checkbox"/>
group or course for quitting smoking	<input type="checkbox"/>	<input type="checkbox"/>
group for quitting the use of alcohol (e.g. AA)	<input type="checkbox"/>	<input type="checkbox"/>
group for quitting the use of some other intoxicant (e.g. NA)	<input type="checkbox"/>	<input type="checkbox"/>
gambling addiction group	<input type="checkbox"/>	<input type="checkbox"/>
patient self-help group (e.g. group of cardiac patients, diabetics or mental health patients)	<input type="checkbox"/>	<input type="checkbox"/>
relaxation exercise or mental training (e.g. yoga, pilates, mindfulness, meditation)	<input type="checkbox"/>	<input type="checkbox"/>
discussion group for grief, divorce, or other life crisis	<input type="checkbox"/>	<input type="checkbox"/>
other: _____	<input type="checkbox"/>	<input type="checkbox"/>

**79. Do you feel you have received enough information on the following municipal services over the past 12 months?**

	no need	not enough information	enough information
health care services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
daycare services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
social services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
education services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
library services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cultural services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
physical activity services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
services for youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**80. Do you feel you have been adequately provided with the following services in your home municipality over the past 12 months?**

	no need	would have needed, but service not received	have used, service was inadequate	have used, service was adequate
library services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
indoors sports facilities (swimming baths, gym, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
outdoors sports facilities (sports fields, outdoor exercise routes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cultural services (cinema, theatre, concerts, exhibitions, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
folk and workers high schools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
youth services, youth facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
children's playgrounds or parks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	no need	would have needed, but service not received	have used, service was inadequate	have used, service was adequate
health centre physician's surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
nurse's surgery at a health centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dental care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
occupational health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
services for the disabled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
services for drug abusers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
social worker's surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
social ombudsman's services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
patient advocate's services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
family planning or birth control clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
maternity and child health clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
children's dental care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
child guidance clinics and family counselling clinics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
children's municipal daycare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
afternoon care for schoolchildren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
home services for families with children, family work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
school health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
student health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pupil counselling (school counsellor, school psychologist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mental health services for children and adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
child welfare services	<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"/>
support for caring relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
financial and debt counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**82. How often have you used the following cultural services over the past 12 months?**

	1 or more times a week	1-3 times a month	a few times in the year	not during the past 12 months
theatre, dance, circus or other performing arts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
concert of classical music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
concert of popular or rock music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
museum or art exhibition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
library	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cinema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
spectator at a sports or fitness event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
spectator at some other cultural event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*The following eleven (11) questions concerning the quality of life form part of the quality of life project of the World Health Organisation (WHO), WHOQOL-BREF, which is available in several languages and provides internationally comparable data. We ask you to think about your life in the past four weeks. Please answer the following questions.*

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

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

**84. 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"/>
your transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**85. 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"/>				
Have you enough opportunities for leisure time activities?	<input type="checkbox"/>				

**86. To what extent do you feel your life to be meaningful?**

- not at all  
 a little  
 moderately  
 mostly  
 completely

**FOR MEN, THIS CONCLUDES THE SURVEY.  
THANK YOU FOR YOUR TIME!**

**You can see the results of the survey at [www.thl.fi/ATH](http://www.thl.fi/ATH)**

*The following three questions only apply to women.*

**88. How many children have you borne?**

*Include both natural births and Caesarean sections.*

- none  
 total childbirths: \_\_\_\_\_

**89. Have you had any abortions?**

- no  
 yes, \_\_\_\_\_ times

**90. Have you had miscarriages or ectopic pregnancies?**

- no  
 yes, \_\_\_\_\_ times

**THANK YOU FOR YOUR TIME!**  
**You can see the results of the survey at [www.thl.fi/ATH](http://www.thl.fi/ATH)**