



Finnish institute for
health and welfare

FinSote

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FinSote

National study of health, well-being and service use

Separate the cover and survey from each other at the broken line



www.finsote.fi



FinSote – NATIONAL STUDY OF HEALTH, WELL-BEING AND SERVICE USE


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 thl.fi/finsote/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 responses!

INSTRUCTIONS TO RESPONDENTS

Answer the questions as follows:

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

EXAMPLE 1.

How would you evaluate your state of health at present?

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

EXAMPLE 2.

Give your present height and weight

height 165 cm

weight 62 kg

More information about the survey:

www.thl.fi/finsote/osallistuvalla

Toll-free number tel. +358 (0)800 97730 (at 9.00-11.00)

e-mail: finsote-info@thl.fi

BACKGROUND INFORMATION

1. Are you currently:

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

2. Are you living in the same household with your partner or spouse at present?

- yes
- no

3. What is your household structure?

Other people living in your household refer to, for example, other relatives, friends or acquaintances who mainly live in the same household. Other type of household refers to, for example, a household shared by more than one family or between friends

- single household
- single parent with at least one child under 25
- single parent with a child/children over 25
- a couple with no child/children
- a couple with at least one child under 25
- a couple with a child/children over 25
- other type of household

4. How many years altogether have you attended school or studied full time? Including primary and comprehensive school.

_____ years

5. How many of the people living in your household are aged 13 or younger?

6. At the moment, are you principally:

- working
- unemployed
- retired (e.g. old-age pension, early retirement or given up entrepreneurship)
- unable to work (e.g. on disability pension)
- pupil, student, in further education or training, or in unpaid practical training
- in conscript or non-military service
- on family leave, or a stay-at-home mother/father
- other



7. Are you currently:

- employed full-time
- employed part-time
- I am not working

8. Your professional status:

- entrepreneur with employees
- entrepreneur or self-employed person with no employees
- employee or officeholders
- working in a family business without pay
- I am not working

HEALTH

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

- very good
- good
- average
- poor
- very poor

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

- yes
- no

11. Are you limited because of a health problem in activities people usually do?

- severely limited
- limited but not severely
- not limited at all → *move on the question 13.*

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

- yes
- no



13. Have you had any of the following illnesses or ailments in the past 12 months?

	yes	no
asthma	<input type="checkbox"/>	<input type="checkbox"/>
chronic bronchitis, chronic obstructive pulmonary disease, emphysema	<input type="checkbox"/>	<input type="checkbox"/>
coronary thrombosis, i.e., myocardial infarction, and its long-term consequences	<input type="checkbox"/>	<input type="checkbox"/>
coronary disease, angina pectoris (=chest pain under physical stress)	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure, hypertensional	<input type="checkbox"/>	<input type="checkbox"/>
cerebral stroke (cerebral haemorrhage or cerebral infarction), and its long-term consequences	<input type="checkbox"/>	<input type="checkbox"/>
osteoarthritis, or degenerative arthritis (excluding arthritis)	<input type="checkbox"/>	<input type="checkbox"/>
low back ailments or other chronic back troubles	<input type="checkbox"/>	<input type="checkbox"/>
neck or neck area symptoms or illnesses	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>
An allergy, such as rhinitis, eye inflammation, dermatitis, food allergy or other allergy (allergic asthma excluded)	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis of the liver	<input type="checkbox"/>	<input type="checkbox"/>
Urinary incontinence, problems in controlling the bladder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
depression	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol or high blood lipids	<input type="checkbox"/>	<input type="checkbox"/>

14. How would you describe the state of your teeth (natural or false) and gums?

- very good
- good
- average
- poor
- very poor

ACCIDENTS

15. Have you had any of the following incidents or accidents over the past 12 months that caused you an injury of some degree?
Do not include any accidents at work.

	yes	no
road accident (Including commuting)	<input type="checkbox"/>	<input type="checkbox"/>
accident at home	<input type="checkbox"/>	<input type="checkbox"/>
leisure time accident (outside home)	<input type="checkbox"/>	<input type="checkbox"/>

if you responded NO to all questions, move on the question 17.

16. Did you need healthcare services for the treatment of the most severe of the injuries referred to above?

- yes, I needed treatment at the emergency care clinic of a hospital or some other care unit admitted as an overnight patient
- yes, I needed treatment at the emergency care clinic of a hospital or some other care unit admitted as a patient, but not overnight
- yes, I needed treatment provided by a physician or nurse (but not as a hospital patient)
- I did not need any treatment

WORK CAPACITY AND ABSENCE FROM WORK

17. 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

Completely incapable for work	0	1	2	3	4	5	6	7	8	9	10	Best capacity for work
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

18. Have you been absent from work because of personal health issues over the past 12 months?

Please include any illnesses, accidents and other health issues because of which you have been absent from work.

- yes, please enter how many days you have been absent from work over the past 12 months:
_____ days
- no
- I am not working

FUNCTIONAL CAPACITY

19. Do you wear glasses or contact lenses?

- yes
- no
- I am blind → *move on the question 21.*

20. Do you have difficulty seeing? *If you wear glasses or contact lenses, please evaluate your vision when wearing them.*

- No difficulty
- Some difficulty
- A lot of difficulty
- I do not see at all

21. Do you use a hearing aid?

- yes
- no
- I am totally deaf → *move on the question 24.*

22. When discussing with another person in a quiet room, do you have difficulty hearing what he or she is saying to you? *If you have a hearing aid, assess your hearing when using it.*

- No difficulty
- Some difficulty
- A lot of difficulty
- I do not hear at all

23. When discussing with another person in a noisy room, do you have difficulty hearing what he or she is saying to you? *If you have a hearing aid, assess your hearing when using it.*

- No difficulty
- Some difficulty
- A lot of difficulty
- I do not hear at all

24. Do you have difficulty walking half a kilometre on a level ground without any aids or assistance from another person?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all / Unable to do

25. Do you have difficulty walking up or down one flight of stairs (about 12 steps)?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all / Unable to do



FEELINGS OF PAIN

26. Have you experienced any physical pain over the past four weeks and what has it been like?

- I have not → move on the question 28.
- very mild
- mild
- moderate
- strong
- very strong

27. In the past four weeks, to what extent has pain affected your ordinary activities at work and/or home?

- not at all
- a little
- to some extent
- quite a lot
- very much

MENTAL HEALTH

28. How often have you experienced the following problems over the past two weeks?

	not at all	on several days	more than half the time	almost daily
Little interest in or little pleasure from doing different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low spirits, depression or feelings of hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty falling as sleep or staying asleep, or too much sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness or lack of strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of inferiority or failure, or a feeling of having let down yourself or your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty concentrating on activities, such as reading a newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slowed speech or movements that others could pay attention to or involuntary restlessness or fidgeted much more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<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.

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

- no
 yes

SOCIAL AND HEALTH CARE SERVICES

30. What is your opinion of the following statements regarding health care services?

Health care services refer to, for instance, health centres and hospitals. Please choose only one alternative on each line.

	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"/>
I trust in the expertise and competence of health service staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The health services increase social equity and fairness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. What is your opinion of the following statements regarding social welfare services?

For example, social welfare services refer to services for elderly people, services for families with children, home services, services for disabled people, counselling provided by a social worker or counsellor, and social assistance. Please choose only one alternative on each line.

	completely agree	somewhat agree	neither agree nor disagree	somewhat disagree	strongly disagree
In general, social welfare services function well in Finland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I trust in the expertise and competence of social service staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The social welfare services increase social equity and fairness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. What is your opinion of the following statements? I trust that when I need the following service, it will be available for me...

Please choose only one alternative on each line.

	completely agree	somewhat agree	neither agree nor disagree	somewhat disagree	strongly disagree
urgent treatment for a sudden, serious illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
regular treatment and monitoring of a long-term illness (e.g. high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
services for the elderly (e.g. services brought home, sheltered housing, residential home for elderly)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
services for disabled people (e.g. transportation services, personal assistance, home alteration work)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
services for families with children (e.g. child welfare services, parenting and family counselling, home services)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
counselling and guidance provided by a social worker or counsellor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
basic social assistance provided by the Social Insurance Institution of Finland (Kela)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
supplementary or preventive social assistance provided by the municipality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. Social and health care services are undergoing a reform. The reform has many different objectives. Below there are listed the objectives set out for the reform at its various stages.

Which three of these objectives you find most important?

	choose the three most important objectives
primary services (e.g. health centre services and social welfare services) are strengthened	<input type="checkbox"/>
the client's case is handled smoothly and information is transferred between professionals	<input type="checkbox"/>
clients and patients have an increasing opportunity to make choices (e.g. on their place of care)	<input type="checkbox"/>
everyone living in Finland will have equal access to services based on their needs (regardless of their income level, place of residence, origin or any other factor)	<input type="checkbox"/>
everyone's responsibility on their own health and well-being and that of their family members will be increased	<input type="checkbox"/>
service and treatment practices will be uniform in the entire country	<input type="checkbox"/>
social and health care costs will remain reasonable	<input type="checkbox"/>

34. To what extent do you feel tax revenue should be used for funding the following services?

	more than currently	as much as currently	less than currently
health and medical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
social welfare services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
transfer payments, such as social benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35. To what extent do you wish customers would use their own funds (as customer fees) in financing the following services?

	more than currently	as much as currently	less than currently
for health and medical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
for social welfare services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

36. Have you acquired a private medical insurance that covers costs resulting from the treatment of an illness in Finland, such as private doctors' fees, medicine costs and fees charged for days spent in hospital?

- yes
- no, but I have considered it
- no, and I have not considered it

37. Have you experienced delay in getting health care in the past 12 months because the time needed to obtain an appointment was too long? Here, delay means that you did not receive treatment or were not referred to an examination soon enough or at all.

- yes
- no
- no, I have not needed any healthcare services

38. Has your access to social services or receiving a specific service been delayed due to long waiting times over the past 12 months? Here, delay means that you did not receive services soon enough or at all.

- yes
- no
- no, I have not needed any socialservices

39. Have you experienced delay in getting health care in the past 12 months due to distance or transportation problems? Here, delay means that you did not receive treatment or were not referred to an examination soon enough or at all.

- yes
- no
- no, I have not needed any healthcare services



40. Was there any time in the past 12 months when you needed the following kinds of health care, but could not afford it?

	yes, I have skipped them	no, I have never skipped them	no need
Medical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescribed medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health care (by a psychologist, psychotherapist or a psychiatrist for example)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITAL CARE

41. In the past 12 months, have you received treatment at a hospital at least overnight? Women, please exclude any potential nights spent at a hospital due to delivery.

- yes, please enter how many nights you have spent in hospital care: _____ nights
- no

42. In the past 12 months, have you visited a hospital as an outpatient, being examined or receiving treatment, without having to stay overnight?

- yes, please enter how many times you have visited a hospital as an outpatient: _____ times
- no

MEDICAL CONSULTATIONS AND NEED OF HOME CARE

43. When was the last time you received treatment from a dentist?

- less than 6 months ago
- 6 – 11 months ago
- at least 12 months ago
- never

44. When was the last time you visited a general practitioner (e.g. occupational doctor or health centre doctor) because of your own health?

Please include any home visits and telephone consultations of a doctor, but do not include the times when you were at a hospital as a patient.

- less than 12 months ago
- at least 12 months ago
- never

45. How many times have you visited a general practitioner (e.g. occupational doctor or health centre doctor) because of your own health over the past four weeks?

_____ times

46. When was the last time you visited a medical specialist because of your own health?

For example, at an outpatient clinic of a hospital or a private practice. Please do not include the times when you were at a hospital as a patient.

- less than 12 months ago
 at least 12 months ago
 never

47. How many times have you visited a medical specialist because of your own health over the past four weeks?

_____ times

48. In the past 12 months, have you visited any of the following practitioners because of your own health:

	yes	no
physiotherapist or similar (e.g. osteopath, naprapath)	<input type="checkbox"/>	<input type="checkbox"/>
psychologist, psychotherapist or psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>

49. Have you used home care services (home help service, home assistance or home nursing) over the past 12 months?

Home help services are meal service and help with cleaning, among others. Home nursing refers to medical care or rehabilitation at home.

- yes
 no

50. Over the past two weeks, have you used:

	yes	no
medicines prescribed by a doctor (other than contraceptive pills or hormones used solely for contraception)	<input type="checkbox"/>	<input type="checkbox"/>
medicines not prescribed by a doctor (e.g. painkillers, natural health products or vitamins)	<input type="checkbox"/>	<input type="checkbox"/>

VACCINATIONS AND MEDICAL EXAMINATIONS

51. Have you taken an influenza vaccine?

- yes, this year or the year before. Enter the month and year when you took the influenza vaccine.

_____ month (e.g. 09), _____ year (e.g. 2018)

- yes, but not this year or the year before
 no, I have never taken an influenza vaccine



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

	less than 12 months ago	1 year to less than 3 years ago	3 years to less than 5 years ago	at least 5 years ago	never
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"/>

53. When was the last time you had a faecal occult blood test?

The test is used for cancer screening, for example.

- less than 12 months ago
- 1 year to less than 2 years ago
- 2 years to less than 3 years ago
- at least 3 years ago
- never

54. When was the last time you had a colonoscopy performed on you?

- less than 12 months ago
- 1 year to less than 2 years ago
- 2 years to less than 3 years ago
- at least 3 years ago
- never

The next question concerns women only. Men → you can proceed to question 56.

55. When was the last time you had the following examinations performed:

	less than 12 months ago	1 year to less than 3 years ago	3 years to less than 5 years ago	at least 5 years ago	never
mammography (breast X-ray)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PAP smear (cervical cancer screening)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEIGHT AND WEIGHT

56. How tall are you?

_____ cm, please round to nearest centimetre

57. How much do you weigh when wearing light clothing?

Pregnant women should enter their weight before pregnancy.

_____ kg, please round to nearest kilogramme.



EXERCISE

58. How physically strenuous is your work? Please choose the alternative that best describes your situation. Here, work refers to both paid and unpaid work, housework, studying or looking for a job (if unemployed).

- my work is mainly sedentary or standing work (e.g. writing, driving, computer work)
- I walk a lot in my work and my work requires moderate physical effort (e.g. cleaning, carrying light burdens, child care)
- my work is strenuous physical work (e.g. carrying heavy burdens, mining work, construction work)
- I am not working or carrying out any worklike tasks

59. On how many days during an ordinary week do you walk uninterruptedly for at least 10 minutes (e.g. commute, way to and from school or going shopping)?

At other times than working hours.

Number of days: _____

60. How much time do you spend walking in total during an ordinary day (walking uninterruptedly for at least 10 minutes)?

At other times than working hours.

- 10 – 29 minutes per day
- 30 – 59 minutes per day
- 1 – 2 hours per day
- 2 – 3 hours per day
- over 3 hours per day

61. On how many days during an ordinary week do you cycle uninterruptedly for at least 10 minutes (e.g. commute, way to and from school or going shopping)?

At other times than working hours.

Number of days: _____

62. How much time do you spend cycling in total during an ordinary day (cycling uninterruptedly for at least 10 minutes)?

At other times than working hours.

- 10 – 29 minutes per day
- 30 – 59 minutes per day
- 1 – 2 hours per day
- 2 – 3 hours per day
- over 3 hours per day



63. 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 a year or less
- I cannot exercise because of an illness or injury

64. How much time do you use in total for recreational exercise during an ordinary week?

Do not include transfers from one place to another on foot or on bicycle.

during an ordinary week

_____ hours

_____ and minutes a week

65. On how many days during an ordinary week do you do exercise that strengthens muscles or enhances muscle tone?

Such as gym workout or circuit training.

Number of days: _____

66. How much time do you spend sitting and reclining on a typical day?

- less than 4 hours
- 4 to less than 6 hours
- 6 to less than 8 hours
- 8 to less than 10 hours
- 10 to less than 12 hours
- 12 hours or more

DIETARY HABITS

67. How often do you eat fruit and/or berries?

Nuts, almonds and juice squeezed from fresh fruit/berries or made from concentrate are not included.

- one or more times a day
- 4 – 6 times a week
- 1 – 3 times a week
- less often than once a week
- never → *move on the question 69.*



68. How many portions of fruit and/or berries do you eat on average during a day?

One portion is, for example, a medium-sized fruit or 1 dl of berries.

Nuts, almonds and juice squeezed from fresh fruit/berries or made from concentrate are not included.

_____ portions

69. How often do you eat vegetables?

Potatoes, vegetable soups or juices made of concentrate or freshly squeezed ingredients are not included.

One portion is, for example, 1.5 dl of salad or grated vegetables or at least three tablespoons of beans.

Legumes are included in the daily portions only once regardless of the amount consumed.

- one or more times a day
- 4 – 6 times a week
- 1 – 3 times a week
- less often than once a week
- never → *move on the question 71.*

70. How many portions of vegetables do you eat on average during a day?

Potatoes or juices are not included.

One portion is, for example, 1.5 dl of salad or grated vegetables or at least three tablespoons of beans.

Legumes are included in the daily portions only once regardless of the amount consumed.

_____ portions

71. How often do you drink 100% pure fruit or vegetable juice, excluding juice made from concentrate or sweetened juice?

Do not include juices or juice drinks made from concentrate or containing sweeteners or supplements.

- one or more times a day
- 4 – 6 times a week
- 1 – 3 times a week
- less often than once a week
- never

72. How often do you drink sugared soft drinks, for example lemonade or cola? Please exclude light, diet or artificially sweetened soft drinks.

- one or more times a day
- 4 – 6 times a week
- 1 – 3 times a week
- less often than once a week
- never



SMOKING

73. Do you smoke at present (other tobacco products than e-cigarettes)?

- yes, daily
 yes, occasionally
 not at all → *move on the question 76.*

74. Do you smoke manufactured or hand-rolled cigarettes each day?

- yes
 no

75. How many cigarettes do you smoke on average during a day?

_____ cigarettes

76. 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

77. How often are you exposed to tobacco smoke indoors (at home, at work, at public places, at restaurants, etc.)?

- Every day, 1 hour or more a day
 Every day, less than 1 hour per day
 At least once a week (but not every day)
 Less than once a week
 Never or almost never

78. Do you currently use snuff?

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

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

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



ALCOHOL

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

- no → move on the question 85.
 yes

81. How often do you consume beer, wine or other alcoholic beverages?

Also include the times when you only had a small amount, e.g. a bottle of medium-strength beer or a sip of wine. Choose the option that best describes your situation.

- never
 around once a month or less
 2 – 4 times a month
 2 – 3 times a week
 4 or more times a week

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

Please refer to the adjacent box.

- 1 – 2 servings
 3 – 4 servings
 5 – 6 servings
 7 – 9 servings
 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.

83. How often have you had six or more drinks on one occasion?

- never
 less than once a month
 once a month
 once a week
 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

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

	during the past 7 days
medium-strength (III) beer, medium-strength cider or long drinks (alcohol content 2.9% to 4.7%)	<input type="text"/>
stronger A beer, strong cider or long drinks (alcohol content over 4.7%)	<input type="text"/>
wine	<input type="text"/>
spirits or other strong drinks	<input type="text"/>



SOCIAL SUPPORT AND PARTICIPATION

85. How many people close to you do you have that you can turn to when encountering serious personal problems?

- none
- 1 – 2
- 3 – 5
- 6 or more

86. To what extent do other people care for what you do?

- a lot
- moderately
- not sure
- a little
- not at all

87. How easy it is for you to get help from your neighbours if you need it?

- very easy
- easy
- possible
- difficult
- very difficult

88. What is your opinion of the following statements?

Please mark for each statement the alternative that best describes your experience.

	strongly disagree	somewhat disagree	neither agree nor disagree	somewhat agree	completely agree
I feel that what I do every day is significant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get positive feedback on what I do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I belong to a group or community that is important for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people need me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can influence the course of my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel my life has a meaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can strive for things that are important for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I receive help when I really need it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel trusted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can influence some things in my living environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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

- no
- yes, actively
- yes, occasionally

90. Did you vote in the most recent Parliamentary elections?

- no
- yes
- I don't remember

PROVIDING CARE AND ASSISTANCE

91. Are you assisting one or more people at least once a week due to problems caused by ageing, chronic illness or other functional disabilities?

You are providing assistance in such tasks as having a wash, shopping groceries or cleaning. This does not refer to paid employment as, for example, a nurse or personal assistant.

- yes
- no → move on the question 95.

92. Is this person: (Select the one to whom you are providing the most care at least once a week.)

If you are assisting more people than one, give your response regarding the person who you assist the most.

- a family member
- other than a family member

93. How many hours do you use in total assisting one or more people during a week?

Include all the people you are assisting during a week.

- less than 10 hours a week
- at least 10 but less than 20 hours a week
- at least 20 hours a week

94. Are you an official informal caregiver (have entered into an agreement)?

- no
- yes

When answering questions number (95 - 96), please consider the past two weeks.

95. How would you rate your quality of life?

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



96. Below are listed some statements regarding emotions and thoughts. For each statement, please check the box that best describes your experiences in the past two weeks.

	never	rarely	sometimes	often	all the time
I have felt hopeful about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have dealt with problems well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have thought clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt closeness with other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have managed to make my own decisions on things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- I filled it in alone
- I was assisted by a person living in the same household
- I was assisted by someone else

THANK YOU FOR YOUR TIME!

You can see the results of the survey at www.thl.fi/finsote

