Supplementary Files

Appendix A. Baseline Questionnaire

Road Trauma Health Outcome Study
Baseline Interview

Participant ID ☐☐-☐☐☐☐☐

Interview Date ☐☐ / ☐☐ / ☐☐☐☐ (m m / d d / y y y y)

Interviewer ID ☐☐

Site (*circle*) **VGH** **RCH** **KGH**

Please indicate who is completing the questionnaire:
☐ Participant ☐ Participant with assistance from another person
☐ Another person on behalf of the participant

For Office Use Only
Baseline Gift Card Received: ☐ Yes ☐ No
REDCap Data Entered: ☐☐ / ☐☐ / ☐☐ (m m / d d / y y)

Appendix A. Baseline Questionnaire

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Appendix A. Baseline Questionnaire

TEMPORARY TRACKING SHEET

****DETACH AND DESTROY THIS SHEET AFTER DATA ENTRY****

Participant ID | | | - | | | | | |

Site Code ID Number

Medical Record Number (MRN): _____

Following data entry, separate this page from the survey and shred it immediately

Appendix A. Baseline Questionnaire

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Appendix A. Baseline Questionnaire

SECTION 1

1. Date of Interview	☐☐ / ☐☐ / ☐☐ (m m / d d / y y)	**Time of Interview**	☐☐ : ☐☐ (24-hour clock)
2. ED Date	☐☐ / ☐☐ / ☐☐ (m m / d d / y y)	**ED Arrival Time**	☐☐ : ☐☐ (24-hour clock)

Interviewer: *Please rate the level of consciousness and speech of participant.*

3. Level of Participant's Consciousness (Check the one that best fits)

- ☐ Alert (eyes open spontaneously)
- ☐ Restless (pressured speech, constantly in motion, easily distracted)
- ☐ Agitated (yelling, threatening, combative)
- ☐ Drowsy (eyes closed but open to voice)
- ☐ Sleeping (does not open eyes to voice)
- ☐ Comatose (does not open eyes to pain)

4. Participant's Speech:

***Interviewer* PROMPT**: "Do you know what time of day it is?"

☐ Yes ☐ No ☐ Don't Know

Participant's Status:

- ☐ Normal conversation and speech, oriented (knows where they are, the date, and their name)
- ☐ Normal conversation, but slurred speech, oriented
- ☐ Confused or disoriented, but speaking in sentences using recognizable words
- ☐ Nonsense or incomprehensible words or phrases, moaning

INTERVIEWER

To give consent, the participant must be alert/oriented.

1. ***If participant is alert and oriented, proceed with consent process and interview.***
2. ***If participant is not alert and oriented, try again later.***
3. ***If participant remains confused or comatose, obtain consent from an appropriate proxy (someone who knows the patient well, e.g. a family member) and interview the proxy.***

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Interviewer: *Unless the participant requests otherwise, the interview should be conducted one-on-one.*

5. Is anyone else present during this interview?
- ☐ Yes
- ☐ No (SKIP TO **QUESTION 6**)

5a. Has the participant specifically requested someone else to be present?
- ☐ Yes
- ☐ No

5b. What is the person/people's relationship(s) to the patient? (Check ALL that apply)
- ☐ Partner / Spouse
- ☐ Family member other than spouse; **Specify: _____**
- ☐ Friend
- ☐ Police
- ☐ Ambulance / Paramedics
- ☐ Other; **Specify: _____**
- ☐ Not Applicable

6. Participant's Consent
- ☐ Yes (Ensure consent/assent form is signed – verbal or written)
- ☐ No

Interviewer: For the remaining questions in the interview, please use the following codes to indicate participant's responses when applicable.
- When a participant answers: "Don't know", write **"DK"** besides the question
- When a participant refuses to answer a question, write **"R"** besides the question
- If a question does not apply to the participant and there is no option for 'Not applicable', write **"NA"** besides the question

Note: All questions can only have ONE response, unless otherwise stated right beside the question

Appendix A. Baseline Questionnaire

SECTION 2

I am going to ask you some questions about the accident. **Please tell me what happened to you during the accident.**

1. Were you a…?

- ☐ Driver
- ☐ Passenger
- ☐ Motorcyclist
- ☐ Pedestrian
- ☐ Cyclist

2. When did this accident occur?

Date (MM/DD/YY): _____

Time (24-hour clock): _____

Interviewer: *If more than 24-hours have passed between the time of the accident and the time of this interview, stop the interview and thank the participant for their time. For admitted patients, the interview can be completed at any time during their admission to the hospital from the time of the accident – try to enrol them as soon as possible.*

Participant's Study Eligibility:

- ☐ Yes (*i.e.* accident occurred within 24 hours of the interview **OR** patients are interviewed about their accident at some point during their admission to the hospital for ADMITTED patients only → proceed with the interview)
- ☐ No (*i.e.* accident occurred over 24 hours ago → stop the interview and thank the participant for their time)

If the participant was a driver or motorcyclist, SKIP TO **SECTION 2A**.
If the participant was a passenger, SKIP TO **SECTION 2B**.
If the participant was a pedestrian, SKIP TO **SECTION 2C**.
If the participant was a cyclist, SKIP TO **SECTION 2D**.

Appendix A. Baseline Questionnaire

SECTION 2A: DRIVER/MOTORCYCLIST

A1. What type of vehicle were you driving?

- ☐ Car, sedan, or convertible (small-sized vehicle)
- ☐ SUV, jeep, light truck, or minivan (medium-sized vehicle)
- ☐ Commercial vehicle, bus, semi-truck, or big truck (large-sized vehicle)
- ☐ Motorcycle / Scooter

A2. How many vehicles were involved in this accident?

- ☐ One (*i.e.* single vehicle – including crashing into parked cars)
- ☐ Two (including your vehicle)
- ☐ Three or more

A3. Do you know the type of the other vehicle(s) involved? (Check ALL that apply)

- ☐ Car, sedan, or convertible (small-sized vehicle)
- ☐ SUV, jeep, light truck, or minivan (medium-sized vehicle)
- ☐ Commercial vehicle, bus, semi-truck, or big truck (large-sized vehicle)
- ☐ Motorcycle / Scooter
- ☐ Not Applicable (*e.g.* single vehicle accidents)
- ☐ Don't Know

A4. Where did the accident occur?

- ☐ Main street (*e.g.* multi-lanes, lots of traffic, *etc.*)
- ☐ Side street (*e.g.* less traffic, residential area, *etc.*)
- ☐ Ramp (*e.g.* exit or entrance ramp, *etc.*)
- ☐ Highway

If uncertain, write participant's response here: _____

A5. Did this accident occur at an intersection?

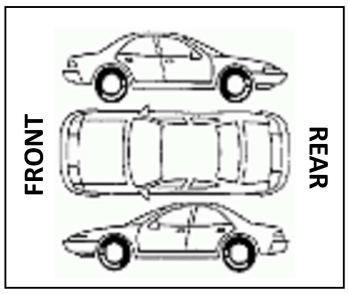
- ☐ Yes
- ☐ No

A6. How fast was your vehicle travelling?

- ☐ Slow speed (< 30 km/hr)
- ☐ Moderate speed (30-60 km/hr)
- ☐ High speed (> 60 km/hr)
- ☐ Don't Know

A7. What side of your vehicle was hit? (Check ALL that apply)

Interviewer: Circle the area(s) of impact on the diagram to the right.



- ☐ Side (right side angle)
- ☐ Side (left side angle)
- ☐ Side (right side swipe)
- ☐ Side (left side swipe)
- ☐ Back (rear-ended)
- ☐ Front (head-on collision)

Appendix A. Baseline Questionnaire

A8. Were you wearing a seatbelt? (If the vehicle was a motorcycle/scooter: Were you wearing a helmet?)

- ☐ Yes
- ☐ No

A9. Was the airbag deployed?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

A10. Did you strike the windshield or any object in the car/motorcycle?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

A11. Was your vehicle severely damaged? For example: Did the vehicle have to be towed away? Was the vehicle drivable after the accident? Could you open the vehicle door? Was there major damage or intrusion into the vehicle**?**

- ☐ Yes
- ☐ No
- ☐ Don't Know

Next: Go to **Section 3**

Appendix A. Baseline Questionnaire

SECTION 2B: PASSENGER

B1. What type of motor vehicle were you a passenger in?

- ☐ Car, sedan, or convertible (small-sized vehicle)
- ☐ SUV, jeep, light truck, or minivan (medium-sized vehicle)
- ☐ Commercial vehicle, bus, semi-truck, or big truck (large-sized vehicle)
- ☐ Motorcycle / Scooter

B2. How many vehicles were involved in this accident?

- ☐ One (*i.e.* single vehicle – including crashing into parked cars)
- ☐ Two (including your vehicle)
- ☐ Three or more

B3. Do you know the type of the other vehicle(s) involved? (Check ALL that apply)

- ☐ Car, sedan, or convertible (small-sized vehicle)
- ☐ SUV, jeep, light truck, or minivan (medium-sized vehicle)
- ☐ Commercial vehicle, bus, semi-truck, or big truck (large-sized vehicle)
- ☐ Motorcycle / Scooter
- ☐ Not Applicable (For single-vehicle accidents)
- ☐ Don't Know

B4. Where did the accident occur?

- ☐ Main street (*e.g.* multi-lanes, lots of traffic, *etc.*)
- ☐ Side street (*e.g.* less traffic, residential area, *etc.*)
- ☐ Ramp (*e.g.* exit or entrance ramp, *etc.*)
- ☐ Highway

If uncertain, write participant's response here: _____

B5. Did this accident occur at an intersection?

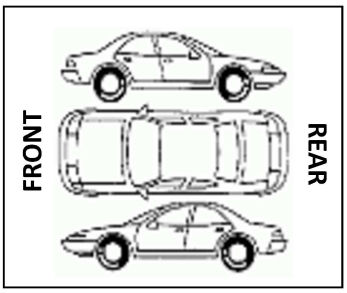
- ☐ Yes
- ☐ No

B6. How fast was the vehicle travelling?

- ☐ Slow speed (< 30 km/hr)
- ☐ Moderate speed (30-60 km/hr)
- ☐ High speed (> 60 km/hr)
- ☐ Don't Know

B7. What side of the vehicle was hit? (Check ALL that apply)

Interviewer: Circle the area(s) of impact on the diagram to the right.



- ☐ Side (right side angle)
- ☐ Side (left side angle)
- ☐ Side (right side swipe)
- ☐ Side (left side swipe)
- ☐ Back (rear-ended)
- ☐ Front (head-on collision)

Appendix A. Baseline Questionnaire

B8. What was your seating location when the accident occurred (vehicle passenger)?

- ☐ Front row: passenger seat
- ☐ Back or middle row: right seat
- ☐ Back or middle row: middle seat
- ☐ Back or middle row: left seat
- ☐ Passenger seat (motorcycle)

B9. Were you wearing a seatbelt (If the vehicle was a motorcycle/scooter: Were you wearing a helmet?)

- ☐ Yes
- ☐ No

B10. Was the airbag deployed?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

B11. Did you strike the windshield or any object in the car/motorcycle?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

B12. Was your vehicle severely damaged? For example: Did the vehicle have to be towed away? Was the vehicle drivable after the accident? Could you open the vehicle door? Was there major damage or intrusion into the vehicle**?**

- ☐ Yes
- ☐ No
- ☐ Don't Know

Next: Go to **Section 3**

Appendix A. Baseline Questionnaire

SECTION 2C: PEDESTRIAN

C1. What type of motor vehicle hit you?

- ☐ Car, sedan, or convertible (small-sized vehicle)
- ☐ SUV, jeep, light truck, or minivan (medium-sized vehicle)
- ☐ Commercial vehicle, bus, semi-truck, or big truck (large-sized vehicle)
- ☐ Motorcycle / Scooter
- ☐ Don't Know

C2. What was the speed of the vehicle that hit you?

- ☐ Slow speed (< 30 km/hr)
- ☐ Moderate speed (30-60 km/hr)
- ☐ High speed (> 60 km/hr)
- ☐ Don't Know

C3. Where did the accident occur?

- ☐ Main street (*e.g.* multi-lanes, lots of traffic, *etc.*)
- ☐ Side street (*e.g.* less traffic, residential area, *etc.*)
- ☐ Ramp (*e.g.* exit or entrance ramp, *etc.*)
- ☐ Highway

If uncertain, write participant's response here: _____

C4. Did the accident occur at an intersection?

- ☐ Yes
- ☐ No

C5. What side of your body did the vehicle hit? (Check ALL that apply)

- ☐ Front
- ☐ Back
- ☐ Left
- ☐ Right

C6. What was the vehicle doing at the time of impact?

- ☐ Turning right
- ☐ Turning left
- ☐ Driving straight
- ☐ Reversing

C7. Which part of the vehicle hit you?

- ☐ Front (*i.e.* vehicle struck you head-on)
- ☐ Back (*i.e.* vehicle was reversing)
- ☐ Side (*e.g.* side swipe)

Next: Go to **Section 3**

Appendix A. Baseline Questionnaire

SECTION 2D: CYCLIST

D1. How fast were you travelling?

- ☐ Slow speed (*e.g.* not going faster than a walking pace / brisk walk)
- ☐ Moderate speed (*e.g.* faster than a brisk walk, but slower than traffic)
- ☐ High speed (*e.g.* with or faster than the speed of traffic)

D2. What type of motor vehicle hit you?

- ☐ Car, sedan, or convertible (small-sized vehicle)
- ☐ SUV, jeep, light truck, or minivan (medium-sized vehicle)
- ☐ Commercial vehicle, bus, semi-truck, or big truck (large-sized vehicle)
- ☐ Motorcycle / Scooter

D3. What was the speed of the vehicle that hit you?

***Interviewer* PROMPT:** Was the vehicle driving over the speed limit?

- ☐ Slow speed (< 30 km/hr)
- ☐ Moderate speed (30-60 km/hr)
- ☐ High speed (> 60 km/hr)
- ☐ Don't Know

D4. Where did the accident occur?

- ☐ Main street (*e.g.* multi-lanes, lots of traffic, *etc.*)
- ☐ Side street (*e.g.* less traffic, residential area, *etc.*)
- ☐ Ramp (*e.g.* exit or entrance ramp, *etc.*)
- ☐ Highway

If uncertain, write participant's response here: _____

D5. Did the accident occur at an intersection?

- ☐ Yes
- ☐ No

D6. Did the vehicle hit you, your bike, or both?

- ☐ Yes, hit cyclist only
- ☐ Yes, hit bike only
- ☐ Yes, hit cyclist and bike

D7. What side of your body did the vehicle hit? (Check ALL that apply)

- ☐ Front
- ☐ Back
- ☐ Left
- ☐ Right

Appendix A. Baseline Questionnaire

D8. What was the vehicle doing at the time of impact?

- ☐ Turning right
- ☐ Turning left
- ☐ Driving straight
- ☐ Reversing

D9. Which part of the vehicle hit you?

- ☐ Front (*i.e.* vehicle struck you head-on)
- ☐ Back (*i.e.* vehicle was reversing)
- ☐ Side (*e.g.* side swipe)

D10. Were you wearing a helmet?

- ☐ Yes
- ☐ No

D11. Besides a helmet, were you wearing any outfit/gear that can provide you some protection from injury?

- ☐ Yes; **Please describe:** _____

  _____
- ☐ No

Next: Go to **Section 3**

Appendix A. Baseline Questionnaire

SECTION 3

1. **Can you tell me the location and type of injury you sustained?** Use the picture and describe the injuries. (Check ALL that apply)

i. Head (skull and brain)
- ☐ Superficial injury
- ☐ Fracture
- ☐ Burn
- ☐ Eye injury
- ☐ Internal injury

ii. Neck
- ☐ Superficial injury
- ☐ Fracture
- ☐ Sprain / Strain

iii. Chest
- ☐ Superficial injury
- ☐ Fracture
- ☐ Burn
- ☐ Internal injury

iv. Abdomen
- ☐ Superficial injury
- ☐ Burn
- ☐ Internal injury

v. Pelvis
- ☐ Superficial injury
- ☐ Fracture
- ☐ Internal injury

vi. Spine (vertebrae)
- ☐ Fracture
- ☐ Dislocation

vii. Back
- ☐ Superficial injury
- ☐ Fracture
- ☐ Internal injury

viii. Upper Extremity
- ☐ Superficial injury
- ☐ Fracture
- ☐ Burn

ix. Lower Extremity
- ☐ Superficial injury
- ☐ Fracture
- ☐ Burn

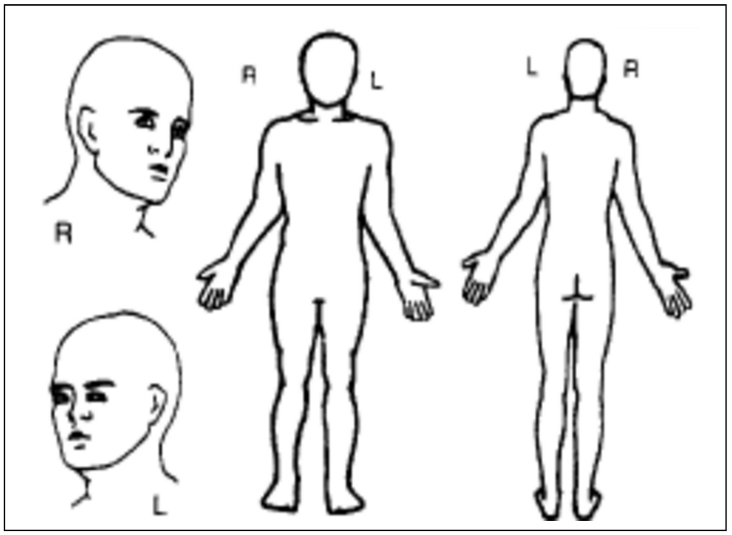
x. Other: _____

_____

_____

_____

_____



Appendix A. Baseline Questionnaire

2. Have you ever had any complaints in the involved body area(s) before this accident?

☐ Yes ☐ No ☐ Don't Know

If yes, were they present at the time of the accident? ☐ Yes ☐ No ☐ Don't Know

If yes, can you tell me about these complaints prior to the accident?

_____

_____

3. At the time of the accident, did you feel any pain immediately after the accident? (Check ALL that apply)

Interviewer: *Prompt the following symptoms.*

☐ Headache
☐ Chest pain
☐ Back pain
☐ Stiff back
☐ Neck pain
☐ Stiff neck
☐ Irritability
☐ Numbness in toes
☐ Face flushed
☐ Cold hands
☐ Cold feet
☐ Shortness of breath
☐ Pins and needles (arms)
☐ Pins and needles (legs)
☐ Ringing in ears
☐ Dizziness
☐ Tension
☐ Memory loss
☐ Other; **Please specify:**

_____

_____

☐ None

4. On a scale of 0 to 10, where '0' is no pain and '10' is the worst pain possible, how much pain are you currently experiencing?

No Pain		Mild		Moderate		Severe		Very Severe		Worst Pain Possible
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Current pain level = ☐

5. How long do you think it will take for you to fully recover from your injuries?

☐ Less than a week
☐ 1 week to less than a month
☐ 1 month to less than 3 months
☐ 3 months to less than 6 months
☐ 6 months or more

Appendix A. Baseline Questionnaire

SECTION 4

The next questions are about your medical history. For the first question, I will ask if you have ever been diagnosed with specific diseases and you can answer "Yes" or "No". **If** you answer "Yes" to any disease, I would appreciate if you can also tell me if you are/have been treated for it or if it has remained untreated.

1. Has a healthcare professional ever diagnosed you with the following?

	Yes	No	Don't Know / Refused	Treating/ Treated	Untreated	Don't Know / Refused	Not Applicable
a. Eye disease	☐	☐	☐	☐	☐	☐	☐
b. Arthritis	☐	☐	☐	☐	☐	☐	☐
c. Diabetes	☐	☐	☐	☐	☐	☐	☐
d. Respiratory disease (*e.g.* COPD)	☐	☐	☐	☐	☐	☐	☐
e. Heart disease	☐	☐	☐	☐	☐	☐	☐
f. Hypertension	☐	☐	☐	☐	☐	☐	☐
g. Cerebrovascular accident (CVA) / Stroke	☐	☐	☐	☐	☐	☐	☐
h. Epilepsy	☐	☐	☐	☐	☐	☐	☐
i. Kidney disease	☐	☐	☐	☐	☐	☐	☐
j. Psychiatric disease	☐	☐	☐	☐	☐	☐	☐
k. Other: _____	☐	☐	☐	☐	☐	☐	☐

2. Are you currently taking any prescribed medications? (Refer to Medical Record Forms)

Interviewer: *Ask the patient to list medications they are currently taking and, if their Medical Record Form is available, ask the patient if they are taking the listed medications (skip those already mentioned).*

_____

_____ ☐ None

3. Are you taking any over-the-counter medications?

☐ Yes; **Specify:** _____

☐ No

4. Do you take any medications for…?

	Yes	No	Don't Know	Refused	Not Applicable
a. Sleep	☐	☐	☐	☐	☐
b. Anxiety	☐	☐	☐	☐	☐
c. Pain	☐	☐	☐	☐	☐
d. Depression	☐	☐	☐	☐	☐

Appendix A. Baseline Questionnaire

5a. Do you ever drink alcohol (including beer, wine, hard liquor, *etc.*)?

- ☐ Yes
- ☐ No (SKIP TO **QUESTION 6A**)

5b. During the last 4 weeks, how often did you have any kind of drink containing alcohol?

- ☐ Daily or almost daily (6 or 7 times a week)
- ☐ Three to five times a week
- ☐ Once or twice a week
- ☐ Less than once a week
- ☐ None in the last 4 weeks

6a. Do you ever use marijuana (including medical marijuana)?

- ☐ Yes
- ☐ No (SKIP TO **QUESTION 7A**)

6b. During the last 4 weeks, how often did you use marijuana (including medical marijuana)?

- ☐ Daily or almost daily (6 or 7 times a week)
- ☐ Three to five times a week
- ☐ Once or twice a week
- ☐ Less than once a week
- ☐ None in the last 4 weeks

7a. Do you ever use any other recreational drugs such as cocaine, heroin, or methamphetamine?

- ☐ Yes
- ☐ No (SKIP TO **SECTION 5**)

7b. Which other recreational drugs have you ever used?

- ☐ Cocaine
- ☐ Heroin (or other opiates such as fentanyl or morphine)
- ☐ Methamphetamine
- ☐ Ecstasy (MDMA)
- ☐ Other; **Please specify:** _____

7c. During the last 4 weeks, how often did you use any of these drugs?

- ☐ More than once a week
- ☐ Less than once a week
- ☐ None in the last 4 weeks

Appendix A. Baseline Questionnaire

SECTION 5

Please indicate which statements best describe your own health state **a day before the accident**.

1. MOBILITY
- ☐ I have no problems in walking about
- ☐ I have slight problems in walking about
- ☐ I have moderate problems in walking about
- ☐ I have severe problems in walking about
- ☐ I am unable to walk about

2. SELF-CARE
- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing or dressing myself
- ☐ I have severe problems washing or dressing myself
- ☐ I am unable to wash or dress myself

3. USUAL ACTIVITIES (*e.g. work, study, housework, family or leisure activities)*
- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

4. PAIN/DISCOMFORT
- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

5. ANXIETY/DEPRESSION
- ☐ I am not anxious or depressed
- ☐ I am slightly anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am severely anxious or depressed
- ☐ I am extremely anxious or depressed

6. We would like to know how good or bad your health was a day before the accident. This scale is numbered from 0 to 100. A '100' indicates the best health you can imagine, while a '0' indicates the worst health you can imagine. Mark an 'X' on the scale to indicate how your health is a day before the accident. Then please write the number you marked on the scale in the box below.

Worst health you can imagine — Best health you can imagine

0 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Your health a day before = ☐

Appendix A. Baseline Questionnaire

SECTION 6

Now I am going to ask you about your general feelings. Please think about how you were feeling in the **past 2 weeks before this accident.**

Over the past 2 weeks, how often have you been bothered by the following problems? (Circle only one answer per question)

	Not at all	Several days	More than half the days	Nearly everyday
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

Appendix A. Baseline Questionnaire

SECTION 7

Please think about your health and conditions **4 weeks prior to this accident**.

1. **In general, would you say your health before this crash was…?** (Check only one box)

   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. **Health and daily activities before this crash.** The following questions are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much? (*Please check only one box per line*)

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table, pushing a vacuum, bowling, or playing golf	☐	☐	☐
b. Climbing several flights of stairs	☐	☐	☐

3. **During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?** (Please answer "Yes" or "No" to each question)

	Yes	No
a. Accomplished less than you would like	☐	☐
b. Limited in the kind of work or other activities	☐	☐

4. **During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?** (Please answer "Yes" or "No" to each question)

	Yes	No
a. Accomplished less than you would like	☐	☐
b. Did not do work or other activities as carefully as usual	☐	☐

5. **During the past 4 weeks, how much did pain interfere with your normal work (including work outside the home and housework)?** (Please check only one box)

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Appendix A. Baseline Questionnaire

Your Feelings: Now we would like to ask about your feelings in health.

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please indicate the one answer that comes closest to the way you have been feeling. (Please check only one box per question)

6. How much time during the past 4 weeks:

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
b. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
c. Have you felt downhearted and low?	☐	☐	☐	☐	☐	☐
d. Has your health limited your social activities (*e.g.* visiting friends or close relatives)?	☐	☐	☐	☐	☐	☐

Appendix A. Baseline Questionnaire

SECTION 8

In the 4 weeks prior to your injury, how much have you been bothered by any of the following problems?

	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, *etc.*)	☐	☐	☐
d. Menstrual cramps or other problems with your periods (WOMEN ONLY)	☐	☐	☐
e. Headaches	☐	☐	☐
f. Chest pain	☐	☐	☐
g. Dizziness	☐	☐	☐
h. Fainting spells	☐	☐	☐
i. Feeling your heart pound or race	☐	☐	☐
j. Shortness of breath	☐	☐	☐
k. Pain or problems during sexual intercourse	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐
n. Feeling tired or having low energy	☐	☐	☐
o. Trouble sleeping	☐	☐	☐

Appendix A. Baseline Questionnaire

SECTION 9

Interviewer: Read the following to the participant.

Everyone experiences painful situations at some point in their lives. Such experience may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are 13 statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

Interviewer: The PCS is a validated questionnaire. Make sure the participant understands that we are asking about their response to physical pain (**not** psychological/emotional or overall pain).

Please tell me how you would describe your different thoughts and feelings about pain ***before this accident.***

0 = Not at all; **1** = To a slight degree; **2** = To a moderate degree; **3** = To a great degree; **4** = All the time

When I'm in pain:

_____ **I become afraid that the pain will get worse.**

_____ **I feel I can't stand it anymore.**

_____ **I can't seem to keep it out of my mind.**

_____ **There's nothing I can do to reduce the intensity of the pain.**

_____ **I wonder whether something serious may happen.**

_____ **It's awful and I feel that it overwhelms me.**

_____ **I worry all the time about whether the pain will end.**

_____ **I keep thinking about how much it hurts.**

_____ **I keep thinking about how badly I want the pain to stop.**

_____ **I feel I can't go on.**

_____ **It's terrible and I think it's never going to get any better.**

_____ **I keep thinking of other painful events.**

_____ **I anxiously want the pain to go away.**

Appendix A. Baseline Questionnaire

SECTION 10

These are questions about your general health and work.

1. **What is the highest degree of education you have achieved?**

   Interviewer: Classify the participant's response under the most appropriate option.

   - ☐ I never finished school or any training program
   - ☐ Primary or elementary school (Kindergarten to Grade 7)
   - ☐ Lower general secondary school (Grades 8 to 10)
   - ☐ Higher general secondary education (Grades 11 and 12)
   - ☐ Junior vocational education (1 to 2 years of trades school/apprenticeship training)
   - ☐ Intermediate vocational education (3 years of trades school/apprenticeship training)
   - ☐ School for higher vocational education (4 or more years of trades school/apprenticeship training)
   - ☐ University (Bachelor's degree or Associate's degree/2-year diploma)
   - ☐ I achieved another degree (Master's or Doctoral degree; or other education); **Specify: _____**

   If uncertain, write participant's response here: _____

2. **What do you do?** Select one option for what you usually do.
   - ☐ I go to school, I am studying (Full-time school, part-time work; *i.e.* more school than work)
   - ☐ I am employed (Full-time work, part-time school; *i.e.* more work than school)
   - ☐ I am self-employed
   - ☐ I am a housewife or househusband
   - ☐ I am unemployed
   - ☐ I am unable to work, for _____%
   - ☐ I am retired or on a pre-pension plan
   - ☐ I do something else; **Specify: _____**

3. **Do you have a paying job?**
   - ☐ Yes
   - ☐ No (SKIP TO **QUESTION 13**)

The following questions refer to your work/job. That is work that you get paid for. If you do not have a paying job? SKIP TO **QUESTION 13**. *Please first read the explanation above the question.*

4. **What is your occupation?** _____

5. **How many days a week do you work? _____ days** (on average)

6. **How many hours a week do you work?** (Count only the hours that you get paid) _____ **hours**

Appendix A. Baseline Questionnaire

The following questions refer to productivity losses.

Interviewer: *The next 3 questions refer to absenteeism (absence from paid work; sick leave).*

7. **Have you worked at all in the last 4 weeks?**
   - ☐ Yes (If yes, SKIP TO **QUESTION 9)**
   - ☐ No

8. **When did you call in sick?** *(Long-term absence)* ☐☐ / ☐☐ / ☐☐
   m m d d y y

   (This is the date that you first got sick earlier than the period of 4 weeks. This is referring to one whole uninterrupted period of missed work as a result of being sick**)**

   Next: *If the participant has not worked in the last 4 weeks and earlier than the last 4 weeks,* SKIP TO **QUESTION 13**. Please first read the explanation above question 13.

9. **Have you missed work in the last 4 weeks as a result of being sick?** *(Short-term absence)*
   - ☐ Yes, I have missed _____ **work days**
   - ☐ No

Interviewer: *The next 3 questions refer to presenteeism (lost workplace productivity).*

10. **During the last 4 weeks, have there been days in which you worked but during that time were bothered by physical or psychological problems?**
    - ☐ Yes (If yes, GO TO **QUESTIONS 11 and 12**)
    - ☐ No (If no, SKIP TO **QUESTION 13** – read the explanation above question 13)

11. **How many days at work were you bothered by physical or psychological problems?** (Only count the days at work in the last 4 weeks) _____ **work days**

12. **On the days that you were bothered by these problems, was it perhaps difficult to get as much work finished as you normally do? On these days how much work could you do on average?** Look at the figures below. A '10' indicates that you were able to do as much work as you normally do, while a '0' indicates that you were unable to do any work on these days. Circle the figure that fits best.

On these days I could not do anything			I was able to do half as much as I normally do						I was able to do just as much as I normally do	
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Appendix A. Baseline Questionnaire

Interviewer: *Productivity losses of unpaid work.*

Interviewer: Please read the following explanation to the participant.

Explanation: Even for unpaid work, you can be bothered by physical or psychological problems. Sometimes as a result you (might) do less. For example, you have trouble caring for your children or doing voluntary work. Or you are unable to run errands and pick up groceries, or to work in the garden. The following questions refer to this.

13. **Thinking only about the past four weeks, were there days in which you were forced to do less unpaid work because of physical or psychological problems?**
    - ☐ Yes (If yes, GO TO **QUESTIONS 14 AND 15**)
    - ☐ No (If no, SKIP TO **SECTION 11**)

14. **How many days did this happen?** (Only count the days in the last 4 weeks) _____ **days**

15. **Imagine that somebody, for example your partner, family member, or friend helped you on these days, and he or she did all the unpaid work that you were unable to do for you. How many hours on average did that person spend doing this on these days?**

    On average _____ hours on these days

Appendix A. Baseline Questionnaire

SECTION 11

To conclude the interview, I would like to ask you some general questions.

1. **What ethnic group or family background do you identify yourself as?** (Check ALL that apply)
   - ☐ Caucasian / White (*e.g.* European)
   - ☐ Chinese
   - ☐ South Asian (*e.g.* East Indian, Pakistani, Sri Lankan)
   - ☐ Black (*e.g.* African, Jamaican or Caribbean)
   - ☐ Filipino
   - ☐ Latin American
   - ☐ Southeast Asian (*e.g.* Cambodian, Indonesian, Laotian, Vietnamese)
   - ☐ Arab (*e.g.* Arabic speaking, Maghrebi)
   - ☐ West Asian (*e.g.* Afghan, Iranian, Israeli, Turkish)
   - ☐ Japanese
   - ☐ Korean
   - ☐ Aboriginal (*e.g.* North American Indian, Métis, Inuit)
   - ☐ Other; **Specify:** _____
   - ☐ Refused

2. **How long have you lived in Canada?**
   - ☐ Entire life
   - ☐ More than 10 years
   - ☐ 5 to 10 years
   - ☐ 2 to 5 years
   - ☐ < 2 years

3. **What type of place do you reside in?**
   - ☐ Own home (*e.g.* house, apartment, renting, basement suite, *etc.*)
   - ☐ Assisted living
   - ☐ Care home (*e.g.* nursing home - regular nursing care, *etc.*)
   - ☐ No fixed address
   - ☐ Other; **Specify:** _____

4. **Who do you reside with?** (Check ALL that apply)
   - ☐ No one (*i.e.* live alone)
   - ☐ Spouse / Partner (or equivalent)
   - ☐ Child / Children (or equivalent)
   - ☐ Parent(s) (or equivalent)
   - ☐ Friend(s) / Roommate(s)
   - ☐ Other; **Specify:** _____

5. **What language do you speak most frequently at home or with family?**

   _____

Appendix A. Baseline Questionnaire

PERMISSION FOR FOLLOW-UP

Participant ID: | | | - | | | | | |

May we have your permission to link your answers in this survey to your health care use (such as hospital visits, doctor visits, and medications) due to this injury? ☐ Yes ☐ No

May we contact you again to ask you questions about your recovery? The first follow-up will be two months from now.

☐ Yes
☐ No (withdraw from the study). **Reason** (*if provided*): _____

If yes, can you provide us your contact information?

First and Last Name: _____ **Preferred Name:** _____

Phone Number: _____ ☐ Home ☐ Mobile ☐ Work

Alternative Phone Number: _____ ☐ Home ☐ Mobile ☐ Work

Mailing Address: _____

City: _____ **Postal Code:** _____

Email Address: _____

Best Time to Contact: _____

What is your preferred method of contact?

☐ Telephone
☐ Email
☐ Mail

What is your preferred method for completing the follow-up interviews?

☐ Telephone
☐ In-person (For this option, the patient has to be willing to come to the research office at VGH)
☐ Online survey
☐ Paper survey

If we are unable to contact you, is there an alternative person we may contact with your permission? If yes, can you provide us with their contact information?

First and Last Name: _____ **Relationship:** _____

Phone Number: _____ ☐ Home ☐ Mobile ☐ Work

Email Address: _____

Best Time to Contact: _____

****DETACH THIS SHEET UPON INPUTTING DATA AND STORE SEPARATELY****

Appendix B. Follow-Up Questionnaire

Road Trauma Health Outcome Study
2- or 4-Month Follow-Up Questionnaire

Participant ID [ ][ ]-[ ][ ][ ][ ][ ]

Interview Date [ ][ ] / [ ][ ] / [ ][ ][ ][ ]
m m d d y y y y

Interviewer ID [ ][ ]

Follow-Up Month [ ][ ]

Site (*circle)* **VGH** **RCH** **KGH**

Method **Telephone** **In-Person**

Please indicate who is completing the questionnaire:
☐ Participant ☐ Participant with assistance from another person
☐ Another person on behalf of the participant

For Office Use Only

F/U Gift Card Received/Mailed/Emailed: ☐ Yes ☐ No

REDCap Data Entered: [ ][ ] / [ ][ ] / [ ][ ]
m m d d y y

Appendix B. Follow-Up Questionnaire

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Appendix B. Follow-Up Questionnaire

SECTION 1

1. **Have you fully recovered from the accident?**
   - ☐ Yes
   - ☐ No

2. **Are you back to your previous daily activities as usual (prior to the accident)?**
   - ☐ Yes
   - ☐ No

3. **Are you back to your previous activities at work or school?**
   - ☐ Yes
   - ☐ No
   - ☐ Not Applicable (I was not working or going to school prior to the accident)

4. **Are you back to your previous recreational activities as usual?**
   - ☐ Yes
   - ☐ No

5. **After you left the hospital, did you have to return to the hospital for your injury from the accident?**
   - ☐ Yes, kept in the hospital overnight
   - ☐ Yes, emergency department only
     - ☐ One time
     - ☐ More than one time
   - ☐ No

6. **Have you seen any physicians or therapists because of your injury from the accident?** (Check ALL that apply)
   - ☐ Family doctor / General Practitioner (GP)
   - ☐ Specialist
   - ☐ Physical Therapist or Physiotherapist (PT) / Occupational Therapist (OT)
   - ☐ Chiropractor
   - ☐ Other; **Please specify:** _____

7. **Did the accident cause you any financial difficulties?**
   - ☐ Yes; **Please describe:** _____
     _____
   - ☐ No

8. **Did the crash cause you any legal difficulties?**
   - ☐ Yes; **Please describe:** _____
     _____
   - ☐ No

Appendix B. Follow-Up Questionnaire

9. **Please tell us about any problems, health-related or otherwise, you might be having due to the accident:**

_____

_____

_____

_____

_____

_____

Appendix B. Follow-Up Questionnaire

SECTION 2

Please indicate which statements best describe your state of health **today**.

1. MOBILITY

- ☐ I have no problems in walking about
- ☐ I have slight problems in walking about
- ☐ I have moderate problems in walking about
- ☐ I have severe problems in walking about
- ☐ I am unable to walk about

2. SELF-CARE

- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing or dressing myself
- ☐ I have severe problems washing or dressing myself
- ☐ I am unable to wash or dress myself

3. USUAL ACTIVITIES (*e.g. work, study, housework, family or leisure activities)*

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

4. PAIN/DISCOMFORT

- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

5. ANXIETY/DEPRESSION

- ☐ I am not anxious or depressed
- ☐ I am slightly anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am severely anxious or depressed
- ☐ I am extremely anxious or depressed

6. We would like to know how good or bad your health is TODAY. This scale is numbered from 0 to 100. A '100' indicates the best health you can imagine, while a '0' indicates the worst health you can imagine. Mark an 'X' on the scale to indicate how your health is TODAY. Then please write the number you marked on the scale in the box below.

Worst health you can imagine — Best health you can imagine

0 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Your health today = ☐

Appendix B. Follow-Up Questionnaire

SECTION 3

Now I am going to ask you about your general feelings. Please think about how you were feeling in the **past 2 weeks**.

For each question, please answer with one of the following responses:

1 = Not at all; **2** = A little bit; **3** = Moderately; **4** = Quite a bit; **5** = Extremely

---

In the past 2 weeks, how much have you been bothered by:

_____ **Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?**

_____ **Repeated, disturbing dreams of a stressful experience from the past?**

_____ **Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?**

_____ **Feeling very upset when something reminded you of a stressful experience from the past?**

_____ **Having physical reactions (*e.g. heart pounding, trouble breathing, or sweating)* when something reminded you of a stressful experience from the past?**

_____ **Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?**

_____ **Avoid activities or situations because they remind you of a stressful experience from the past?**

_____ **Trouble remembering important parts of a stressful experience from the past?**

_____ **Loss of interest in things that you used to enjoy?**

_____ **Feeling distant or cut off from other people?**

_____ **Feeling emotionally numb or being unable to have loving feelings for those close to you?**

_____ **Feeling as if your future will somehow be cut short?**

_____ **Trouble falling or staying asleep?**

_____ **Feeling irritable or having angry outbursts?**

_____ **Having difficulty concentrating?**

_____ **Being "super alert" or watchful or on guard?**

_____ **Feeling jumpy or easily startled?**

Appendix B. Follow-Up Questionnaire

SECTION 4

Please think about your health and conditions in the **past 4 weeks**.

1. **In general, would you say your health in the past 4 weeks was…?** (Check only one box)

   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. **Health and daily activities.** The following questions are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much? (*Please check only one box per line*)

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table, pushing a vacuum, bowling, or playing golf	☐	☐	☐
b. Climbing several flights of stairs	☐	☐	☐

3. **During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?** (Please answer "Yes" or "No" to each question)

	Yes	No
a. Accomplished less than you would like	☐	☐
b. Limited in the kind of work or other activities	☐	☐

4. **During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?** (Please answer "Yes" or "No" to each question)

	Yes	No
a. Accomplished less than you would like	☐	☐
b. Did not do work or other activities as carefully as usual	☐	☐

5. **During the past 4 weeks, how much did pain interfere with your normal work (including work outside the home and housework)?** (Please tick only one box)

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Appendix B. Follow-Up Questionnaire

Your Feelings: Now we would like to ask about your feelings in health

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please indicate the one answer that comes closest to the way you have been feeling. (Please check only one box per question)

6. How much time during the past 4 weeks:

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
b. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
c. Have you felt downhearted and low?	☐	☐	☐	☐	☐	☐
d. Has your health limited your social activities (*e.g.* visiting friends or close relatives)?	☐	☐	☐	☐	☐	☐

Appendix B. Follow-Up Questionnaire

SECTION 5

During the past 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, *etc.*)	☐	☐	☐
d. Menstrual cramps or other problems with your periods (WOMEN ONLY)	☐	☐	☐
e. Headaches	☐	☐	☐
f. Chest pain	☐	☐	☐
g. Dizziness	☐	☐	☐
h. Fainting spells	☐	☐	☐
i. Feeling your heart pound or race	☐	☐	☐
j. Shortness of breath	☐	☐	☐
k. Pain or problems during sexual intercourse	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐
n. Feeling tired or having low energy	☐	☐	☐
o. Trouble sleeping	☐	☐	☐

Appendix B. Follow-Up Questionnaire

SECTION 6

The questions in this section focus on how your injury affected your overall quality-of-life. We understand that some questions may not apply to you very well depending on the type of injuries you sustained. Please answer each question to the best of your ability.

Please answer the first question if you are not the participant. If you are the participant, please **SKIP TO QUESTION 2A**.

Consciousness

1. Is the participant able to obey simple commands or say any words?

- ☐ Yes
- ☐ No

Independence at Home

2a. Is the assistance of another person at home essential every day for some activities of daily living?

- ☐ Yes
- ☐ No (If no, SKIP TO **QUESTION 3A**)

2b. Do you need frequent help of someone to be around at home most of the time?

- ☐ Yes
- ☐ No

2c. Was assistance at home essential before the injury?

- ☐ Yes
- ☐ No

Independence Outside of the Home

3a. Are you able to shop without assistance?

- ☐ Yes
- ☐ No

3b. Were you able to shop without assistance before the injury?

- ☐ Yes
- ☐ No

4a. Are you able to travel locally without assistance?

- ☐ Yes
- ☐ No

4b. Were you able to travel without assistance before the injury?

- ☐ Yes
- ☐ No

Work

5a. Are you currently able to work to your previous capacity?

- ☐ Yes (If yes, GO TO **QUESTION 6A**)
- ☐ No

Appendix B. Follow-Up Questionnaire

5b. How restricted are you?

- ☐ Reduced work capacity
- ☐ Able to work only in a sheltered workshop or non-competitive job or currently unable to work

5c. Were you working or seeking employment before the injury?

- ☐ Yes
- ☐ No

Social and Leisure Activities

6a. Are you able to resume regular social and leisure activities outside home?

- ☐ Yes (If yes, GO TO **QUESTION 7A**)
- ☐ No

6b. What is the extent of restriction on your social and leisure activities?

- ☐ Participate a bit less; at least half as often as before the injury
- ☐ Participate much less or unable to participate

Family and Friendships

7a. Has there been family or friendship disruption due to psychological problems?

- ☐ Yes
- ☐ No (If no, SKIP TO **QUESTION 8A**)

7b. What has been the extent of disruption or strain?

- ☐ Occasional – less than weekly
- ☐ Frequent or constant – once a week or more

7c. Did you have problems with family or friends before the injury?

- ☐ Yes
- ☐ No

Return to Normal Life

8a. Are there any other current problems relating to your injury which affect your daily life?

- ☐ Yes
- ☐ No (If not, SKIP TO **QUESTION 9A)**

8b. If similar problems were present before the injury, have these become markedly worse?

- ☐ Yes
- ☐ No

Epilepsy

9a. Since the injury, have you had an epileptic fit?

- ☐ Yes
- ☐ No

9b. Have you been told you are currently at risk of developing epilepsy?

- ☐ Yes
- ☐ No

Appendix B. Follow-Up Questionnaire

SECTION 7

These are questions about your health and work following your accident.

We know we asked you the following questions before, but we want to know whether anything has changed since we last interviewed you.

1. What is the highest degree of education you have achieved?

Interviewer: Classify the participant's response under the most appropriate option.

- ☐ I never finished school or any training program
- ☐ Primary or elementary school (Kindergarten to Grade 7)
- ☐ Lower general secondary school (Grades 8 to 10)
- ☐ Higher general secondary education (Grades 11 and 12)
- ☐ Junior vocational education (1 to 2 years of trades school/apprenticeship training)
- ☐ Intermediate vocational education (3 years of trades school/apprenticeship training)
- ☐ School for higher vocational education (4 or more years of trades school/apprenticeship training)
- ☐ University (Bachelor's or Associate's degree/2-year diploma)
- ☐ I achieved another degree (Master's or Doctoral degree; or other education); **Specify:** _____

If uncertain, write participant's response here: _____

2. What do you do? Select one option for what you usually do.

- ☐ I go to school, I am studying (Full-time school only or full-time school, part-time work; *i.e.* more school than work)
- ☐ I am employed (Full-time work only or full-time work, part-time school; *i.e.* more work than school)
- ☐ I am self-employed
- ☐ I am a housewife or househusband
- ☐ I am unemployed
- ☐ I am unable to work, for _____%
- ☐ I am retired or on a pre-pension plan
- ☐ I do something else; **Specify:** _____

3. Do you have a paying job?

- ☐ Yes
- ☐ No (SKIP TO **QUESTION 14**)

The following questions refer to your work/job. That is work that you get paid for. If you do not have a paying job? SKIP TO **QUESTION 14**. *Please first read the explanation above the question.*

4. What is your occupation? _____

5. How many days a week do you currently work? _____ days

6. How many hours a week do you currently work? (Count only the hours that you get paid) _____ **hours**

Appendix B. Follow-Up Questionnaire

The following questions refer to productivity losses.

Interviewer: *The next 4 questions refer to absenteeism (absence from paid work; sick leave).*

7. **Have you returned to work at all since the accident?**
   - ☐ Yes
   - ☐ No (If no, SKIP TO **QUESTION 14)**

8. **Have you worked at all in the last 4 weeks?**
   - ☐ Yes (If yes, SKIP TO **QUESTION 10)**
   - ☐ No

9. **When did you call in sick?** *(Long-term absence)* ☐☐ / ☐☐ / ☐☐
   m m d d y y

   (This is the date that you first got sick earlier than the period of 4 weeks. This is referring to <u>one whole uninterrupted period of missed work</u> as a result of being sick**)**

   <u>Next</u>: *If the participant called in sick in the last 4 weeks and earlier than the last 4 weeks,* SKIP TO **QUESTION 14**. Please first read the explanation above question 14.

10. **Have you missed work in the last 4 weeks as a result of being sick?** *(Short-term absence)*
    - ☐ Yes, I have missed _____ **work days**
    - ☐ No

Interviewer: *The next 3 questions refer to presenteeism (lost workplace productivity).*

11. **During the last 4 weeks, have there been days in which you worked but during that time were bothered by physical or psychological problems?**
    - ☐ Yes (If yes, GO TO **QUESTIONS 12 and 13**)
    - ☐ No (If no, SKIP TO **QUESTION 14** – read the explanation above question 14)

12. **How many days at work were you bothered by physical or psychological problems?** (Only count the <u>days at work</u> in the last 4 weeks) _____ **work days**

13. **On the days that you were bothered by these problems, was it perhaps difficult to get as much work finished as you normally do? On these days how much work could you do on average?** Look at the figures below. A '10' indicates that you were able to do as much work as you normally do, while a '0' indicates that you were unable to do any work on these days. Circle the number that fits best.

On these days I could not do anything			I was able to do half as much as I normally do					I was able to do just as much as I normally do		
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Appendix B. Follow-Up Questionnaire

Interviewer: *Productivity losses of unpaid work.*

Interviewer: Please read the following explanation to the participant.

Explanation: Even for unpaid work, you can be bothered by physical or psychological problems. Sometimes as a result you (might) do less. For example, you have trouble caring for your children or doing voluntary work. Or you are unable to run errands and pick up groceries, or to work in the garden. The following questions refer to this.

14. **Thinking only about the past four weeks, were there days in which you were forced to do less unpaid work because of physical or psychological problems?**
    - ☐ Yes (If yes, GO TO **QUESTIONS 15 AND 16**)
    - ☐ No (If no, SKIP TO THE **NEXT SECTION**)

15. **How many days did this happen?** (Only count the days in the last 4 weeks) _____ **days**

16. **On the days that you were forced to do less unpaid work because of physical or psychological problems, how many hours per day would you need help from a family member or friend to help you with your unpaid work on these days?**

    On average _____ hours on these days

Appendix B. Follow-Up Questionnaire

POST-INTERVIEW AND PERMISSION FOR FOLLOW-UP

Thank you for taking the time to complete this questionnaire. As a reminder, your answers will remain confidential and will only be used for research purposes.

May we contact you again in 2 months to ask you questions about your recovery?

☐ Yes

☐ No (withdraw from the study). **Reason** (*if provided*): _____

How would you like to receive your $10 gift card?

☐ By Mail (**Please provide your full mailing address below to receive your gift card**)

Please select one: ☐ Starbucks ☐ Tim Hortons ☐ McDonalds ☐ Superstore ☐ Shoppers Drug Mart ☐ Save-On Foods

☐ By Email: E-gift card (**Please provide your email address below to receive your e-gift card**)

If e-gift card, please select one: ☐ Starbucks ☐ Tim Hortons ☐ Amazon ☐ Chapters

Please provide us with your contact information:

First and Last Name: _____ **Preferred Name:** _____

Phone Number: _____ ☐ Home ☐ Mobile ☐ Work

Alternative Phone Number: _____ ☐ Home ☐ Mobile ☐ Work

Mailing Address: _____

City: _____ **Postal Code:** _____

Email Address: _____

Best Time to Contact: _____

What is your preferred method of contact? ☐ Telephone ☐ Email ☐ Mail

What is your preferred method for completing the follow-up interviews?

☐ Telephone ☐ In-Person (at VGH Research Pavilion) ☐ Online Survey ☐ Paper Survey

If we are unable to contact you, is there an alternative person we may contact with your permission? If yes, can you provide us with their contact information?

First and Last Name: _____ **Relationship:** _____

Phone Number: _____ ☐ Home ☐ Mobile ☐ Work

Email Address: _____

Best Time to Contact: _____

****DETACH AND DESTROY THIS SHEET UPON INPUTTING DATA AND MAILING GIFT CARD OR EMAILING E-GIFT CARD TO PARTICIPANT****