



Health Update Form

English ▼

Top-Level Questions

Please note that this survey is for research purposes only and responses should not be used as a means to communicate with study staff for immediate follow up.

In the past week, have you been away from home overnight?

- ☐ Yes
- ☐ No

Thank you, we will ask for more details about your time away from home after you complete this page.

In the past week, have you had visitors who stayed with you *in your home* for a night or more?

- ☐ Yes
- ☐ No

Thank you, we will ask for more details about your overnight visitor(s) after you complete this page.

In the past week, have you had a change to any of your medications *OR* started a new one?

- ☐ Yes
- ☐ No

Thank you, we will ask for more details about your medication change(s) after you complete this page.

Please note - medication changes may include:

- New medication **started**
- **Switched** medications
- Dosage **increased**
- Dosage **decreased**
- Taking it **more** often
- Taking it **less** often
- **Stopped** taking it

In the past week, have you had a fall, including a slip or trip, in which you lost your balance and landed on the floor, the ground or a lower level?

- ☐ Yes
- ☐ No

Thank you, we will ask for more details about your fall(s) after you complete this page.

In the past week, have you had any other injuries or accidents?

- ☐ Yes
- ☐ No

Thank you, we will ask for more details about your injury or accident(s) after you complete this page.

In the past week, have you had any hospitalizations or emergency room visits (*not including routine doctor visits*)?

☐ Yes

☐ No

Thank you, we will ask for more details about your hospitalization(s) or emergency room visit(s) after you complete this page.

In the past week, has your physical health limited you more than usual? For instance, did illness, pain or arthritis keep you in bed or less active?

☐ Yes

☐ No

Thank you, we will ask for more details about your physical health limitations after you complete this page.

In the past week, have you had any changes in your home-space or living situation? For example, repair or renovation projects, moved or rearranged furniture, someone has moved in or is no longer living with you, or you have a new computer or cell phone.

☐ Yes

☐ No

Thank you, we will ask for more details about your home-space or living situation change(s) after you complete this page.

Please note - home-space changes may include:

- I have a new **computer** or **cell phone**
- Home **repair** or **renovation**
- **Moved** or **rearranged** existing furniture
- **Added** or **removed** old furniture
- Someone **moved in** with me or **moved out** of my home
- **I moved** to a new home

In the past week, is someone *newly* assisting you with medication management, bathing, dressing or grooming?

- ☐ Yes
- ☐ No

Thank you, we will ask for more details about your new in-home helper after you complete this page.

Have you felt downhearted or blue for three or more days in the past week?

- ☐ Yes
- ☐ No

Thank you, we will ask for more details about feeling downhearted or blue after you complete this page.

In the past week I felt lonely.

- ☐ Yes
- ☐ No

Thank you, we will ask for more details about feeling lonely after you complete this page.

Please rate your pain by indicating the number that best describes your pain on average in the last week.

	0	1	2	3	4	5	6	7	8	9	10	
No Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Worst Imaginable

During the past week, how much did pain interfere with your normal activities or work (including both work outside the home and housework)?

	Not at all	Slightly	Moderately	Quite a bit	Extremely
Pain interfered with my normal activities...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Away from Home - Subquestions

You indicated that you have been away from home **overnight** in the last week. Please answer the following questions about your trip.

*If you were away from home more than once this week, please provide information about just the **first** overnight trip below.*

What date did you **leave**? (Please select from calendar below.)

◀
October 2021
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Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16

17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

What date did you **return**? (Please select from calendar below.)

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Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Please briefly describe your trip:

Did you have any other trips away from home in the past week?

- ☐ Yes
- ☐ No

*Please answer the following questions about just your **second** overnight trip away from home in the past week.*

What date did you **leave**? (Please select from calendar below.)

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Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	1	2
3	4	5	6	7	8	9
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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

What date did you **return**? (Please select from calendar below.)

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Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	1	2
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10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Please briefly describe your trip:

Did you have any other trips away from home in the past week?

☐ Yes

☐ No

*Please answer the following questions about just your **third** overnight trip away from home in the past week.*

What date did you **leave**? (Please select from calendar below.)

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Sun	Mon	Tue	Wed	Thu	Fri	Sat
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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

What date did you **return**? (Please select from calendar below.)

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10	11	12	13	14	15	16
17	18	19	20	21	22	23

24	25	26	27	28	29	30
31	1	2	3	4	5	6

Please briefly describe your trip:

Did you have any other trips away from home in the past week?

☐ Yes

☐ No

Please briefly describe any additional overnight trips away from home in the past week:

Overnight Visitors - Subquestions

You indicated that you had one or more visitors stay in your home **overnight** in the past week. Please answer the following questions about your visitor(s).

*If you had visitors more than once this week, please provide information about just the **first** overnight visit below.*

What date did your visitor(s) **arrive**? (Please select from calendar below.)

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Sun	Mon	Tue	Wed	Thu	Fri	Sat

Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	1	2
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10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

What date did your visitor(s) **leave**? (Please select from calendar below.)

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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

What is this visitor’s relationship to you? (Check all that apply.)

- ☐ Family
- ☐ Partner
- ☐ Friend
- ☐ Caregiver
- ☐ Other, please explain below:

Please briefly describe this visit:

Did you have any other overnight visitors stay in your home in the past week?

- ☐ Yes
- ☐ No

*Please answer the following questions about your **second** overnight visitor(s) in your home in the past week.*

What date did your visitor(s) **arrive**? (Please select from calendar below.)

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Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	1	2
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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

What date did your visitor(s) **leave**? (Please select from calendar below.)

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Sun	Mon	Tue	Wed	Thu	Fri	Sat
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10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

What is this visitor's relationship to you? (Check all that apply.)

- ☐ Family
- ☐ Partner
- ☐ Friend
- ☐ Caregiver
- ☐ Other, please explain below:

Please briefly describe this visit:

Did you have any other overnight visitors stay in your home in the past week?

- ☐ Yes
- ☐ No

*Please answer the following questions about your **third** overnight visitor(s) in your home in the past week.*

What date did your visitor(s) **arrive**? (Please select from calendar below.)

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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

What date did your visitor(s) **leave**? (Please select from calendar below.)

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3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

What is this visitor’s relationship to you? (Check all that apply.)

- ☐ Family
- ☐ Partner
- ☐ Friend
- ☐ Caregiver

☐

Other, please explain below:

Please briefly describe this visit:

Did you have any other overnight visitors stay in your home in the past week?

☐

Yes

☐

No

Please briefly describe any additional overnight visitors in your home in the past week:

Medication - Subquestions

You indicated that you had medication changes in the last week. Please answer the following questions about your medication changes.

*If you had more than one medication change this week, please provide information about just the **first** medication change below.*

For your first medication change, what happened? (Check all that apply.)

☐**New medication** started☐**Switched** to a **different** medication for same issue

- ☐ Dosage **increased** - *for example, increased dose from 10mg to 20mg or increased frequency from once a day to twice a day*
- ☐ Dosage **decreased** - *for example, decreased dose from 20mg to 10mg or decreased frequency from twice a day to once a day*
- ☐ **Stopped** taking it

What is the name of the medication that you started or changed? If you switched medications, what was the **old** medication you switched off of?

What is the name of the **new** medication that you switched to?

What are/were you taking this medication for?

Are/were you taking this medication to reduce pain?

- ☐ Yes
- ☐ No

Is this a temporary medication change (taking for less than **one month**)?

- ☐ Yes
- ☐ No

What date did your medication change? (Please select from calendar below.)



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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Please briefly describe any other important information about this medication change:

Did you have any other medication changes in the past week?

- ☐ Yes
- ☐ No

*Please answer the following questions about your **second** medication change in the past week.*

How did your medication change? (Check all that apply.)

- ☐ **New medication** started
- ☐ **Switched** to a **different** medication for same issue
- ☐ Dosage **increased** - *for example, increased dose from 10mg to 20mg or increased frequency from once a day to twice a day*
- ☐ Dosage **decreased** - *for example, decreased dose from 20mg to 10mg or decreased frequency from twice a day to once a day*
- ☐ **Stopped** taking it

What is the name of the medication that you started or changed? If you switched medications, what was the **old** medication you switched off of?

What is the name of the **new** medication that you switched to?

What are/were you taking this medication for?

Are/were you taking this medication to reduce pain?

☐ Yes

☐ No

Is this a temporary medication change (taking for less than **one month**)?

☐ Yes

☐ No

What date did your medication change? (Please select from calendar below.)

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3	4	5	6	7	8	9
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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Please briefly describe any other important information about this medication change:

Did you have any other medication changes in the past week?

- ☐ Yes
- ☐ No

Please answer the following questions about your **third** medication change in the past week.

How did your medication change? (Check all that apply.)

- ☐ **New medication** started
- ☐ **Switched** to a **different** medication for same issue
- ☐ Dosage **increased** - *for example, increased dose from 10mg to 20mg or increased frequency from once a day to twice a day*
- ☐ Dosage **decreased** - *for example, decreased dose from 20mg to 10mg or decreased frequency from twice a day to once a day*
- ☐ **Stopped** taking it

What is the name of the medication that you started or changed? If you switched medications, what was the **old** medication you switched off of?

What is the name of the **new** medication that you switched to?

What are/were you taking this medication for?

Are/were you taking this medication to reduce pain?

- ☐ Yes
- ☐ No

Is this a temporary medication change (taking for less than **one month**)?

- ☐ Yes
- ☐ No

What date did your medication change? (Please select from calendar below.)

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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Please briefly describe any other important information about this medication change:

Did you have any other medication changes in the past week?

- ☐ Yes
- ☐ No

*Please answer the following questions about your **fourth** medication change in the past week.*

How did your medication change? (Check all that apply.)

- ☐ **New medication** started
- ☐ **Switched** to a **different** medication for same issue
- ☐ Dosage **increased** - *for example, increased dose from 10mg to 20mg or increased frequency from once a day to twice a day*
- ☐ Dosage **decreased** - *for example, decreased dose from 20mg to 10mg or decreased frequency from twice a day to once a day*
- ☐ **Stopped** taking it

What is the name of the medication that you started or changed? If you switched medications, what was the **old** medication you switched off of?

What is the name of the **new** medication that you switched to?

What are/were you taking this medication for?

Are/were you taking this medication to reduce pain?

☐ Yes

☐ No

Is this a temporary medication change (taking for less than **one month**)?

☐ Yes

☐ No

What date did your medication change? (Please select from calendar below.)

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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Please briefly describe any other important information about this medication change:

Did you have any other medication changes in the past week?

- ☐ Yes
- ☐ No

*Please answer the following questions about your **fifth** medication change in the past week.*

How did your medication change? (Check all that apply.)

- ☐ **New medication** started
- ☐ **Switched** to a **different** medication for same issue
- ☐ Dosage **increased** - *for example, increased dose from 10mg to 20mg or increased frequency from once a day to twice a day*
- ☐ Dosage **decreased** - *for example, decreased dose from 20mg to 10mg or decreased frequency from twice a day to once a day*
- ☐ **Stopped** taking it

What is the name of the medication that you started or changed? If you switched medications, what was the **old** medication you switched off of?

What is the name of the **new** medication that you switched to?

What are/were you taking this medication for?

Are/were you taking this medication to reduce pain?

- ☐ Yes

☐ No

Is this a temporary medication change (taking for less than **one month**)?

☐ Yes☐ No

What date did your medication change? (Please select from calendar below.)

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3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Please briefly describe any other important information about this medication change:

Did you have any other medication changes in the past week?

☐ Yes☐ No

Please briefly describe any additional medication changes you have had in the past week:

Falls - Subquestions

You indicated that you had a fall in the last week. Please answer the following questions about your fall.

*If you had more than one fall this week, please provide information about just the **first** fall below.*

What was the date of your fall? (Please select from calendar below.)

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Sun	Mon	Tue	Wed	Thu	Fri	Sat
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3	4	5	6	7	8	9
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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Did you injure yourself in this fall?

- ☐ Yes
- ☐ No

Please briefly describe your fall:

Did you have any other falls in the past week?

☐ Yes

☐ No

*Please answer the following questions about your **second** fall in the past week.*

What was the date of your fall? (Please select from calendar below.)

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Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	1	2
3	4	5	6	7	8	9
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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Did you injure yourself in this fall?

☐ Yes

☐ No

Please briefly describe your fall:

Did you have any other falls in the past week?

☐ Yes

☐ No

*Please answer the following questions about your **third** fall in the past week.*

What was the date of your fall? (Please select from calendar below.)

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10	11	12	13	14	15	16	
17	18	19	20	21	22	23	
24	25	26	27	28	29	30	
31	1	2	3	4	5	6	

Did you injure yourself in this fall?

☐ Yes

☐ No

Please briefly describe your fall:

Did you have any other falls in the past week?

☐ Yes

☐ No

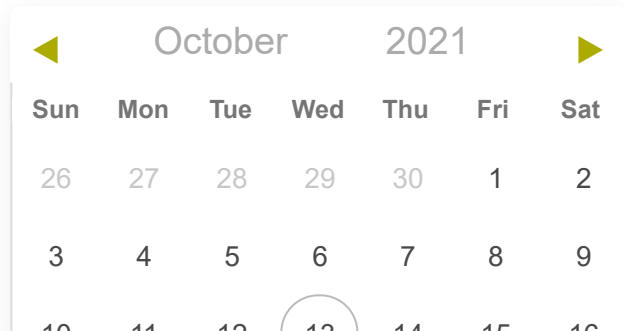
Please briefly describe any additional falls you had in the past week:

Injuries/Accidents - Subquestions

You indicated that you had an injury or accident other than a fall in the last week. Please answer the following questions about your injury or accident.

*If you had more than one injury or accident this week, please provide information about just the **first** injury or accident below.*

What was the date of your injury or accident? (Please select from calendar below.)



10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

What type of injury or accident was it? (Check all that apply.)

- ☐ Personal injury
- ☐ Car accident
- ☐ Damaged property
- ☐ Injured someone else
- ☐ Other, please explain below:

Please briefly describe this injury or accident:

Did you have any other injuries or accidents (other than falls) in the past week?

- ☐ Yes
- ☐ No

*Please answer the following questions about your **second** injury or accident in the past week.*

What was the date of your injury or accident? (Please select from calendar below.)

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Sun	Mon	Tue	Wed	Thu	Fri	Sat
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26	27	28	29	30	1	2
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10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

What type of injury or accident was it? (Check all that apply.)

- ☐ Personal injury
- ☐ Car accident
- ☐ Damaged property
- ☐ Injured someone else
- ☐ Other, please explain below:

Please briefly describe this injury or accident:

Did you have any other injuries or accidents (other than falls) in the past week?

- ☐ Yes
- ☐ No

*Please answer the following questions about your **third** injury or accident in the past week.*

What was the date of your injury or accident? (Please select from calendar below.)



What type of injury or accident was it? (Check all that apply.)

- ☐ Personal injury
- ☐ Car accident
- ☐ Damaged property
- ☐ Injured someone else
- ☐ Other, please explain below:

Please briefly describe this injury or accident:

Did you have any other injuries or accidents (other than falls) in the past week?

- ☐ Yes
- ☐ No

Please briefly describe any additional injuries or accidents (other than falls) that you had in the past week:

Hospitalizations - Subquestions

You indicated that you had a hospital or emergency room visit in the last week. Please answer the following questions about your hospitalization.

*If you had more than one hospitalization this week, please provide information about just the **first** hospital visit below.*

What was the start date of your hospital or emergency room visit? (Please select from calendar below.)

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31	1	2	3	4	5	6

Was the visit planned?

- ☐ Yes
- ☐ No

Did you visit the emergency room as part of this visit?

- ☐ Yes
- ☐ No

Were you admitted to the hospital as part of this visit?

- ☐ Yes
- ☐ No
- ☐ I'm not sure

Did you stay overnight in the hospital?

- ☐ Yes
- ☐ No

What date did you leave the hospital? (Please select from calendar below.)

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26	27	28	29	30	1	2
3	4	5	6	7	8	9
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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

What were you treated for?

Please briefly describe any other important information about this hospitalization:

Did you have any other hospital or emergency room visits in the past week?

- ☐ Yes
- ☐ No

*Please answer the following questions about your **second** hospital or emergency room visit in the past week.*

What was the start date of your hospital or emergency room visit? (Please select from calendar below.)

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31	1	2	3	4	5	6

Was the visit planned?

- ☐ Yes
- ☐ No

Did you visit the emergency room as part of this visit?

- ☐ Yes
- ☐ No

Were you admitted to the hospital as part of this visit?

- ☐ Yes
- ☐ No
- ☐ I'm not sure

Did you stay overnight in the hospital?

- ☐ Yes
- ☐ No

What date did you leave the hospital? (Please select from calendar below.)

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10	11	12	13	14	15	16
17	18	19	20	21	22	23

24	25	26	27	28	29	30
31	1	2	3	4	5	6

What were you treated for?

Please briefly describe any other important information about this hospitalization:

Did you have any other hospital or emergency room visits in the past week?

- ☐ Yes
- ☐ No

Please briefly describe any additional hospital or emergency room visits that you had in the past week:

Physical Health Limitation - Subquestions

You indicated that your health has limited you more than usual this week. Please describe how your health has been limiting this week:

Please indicate if any of these specific items below are related to your health limitations. Check all that may apply:

- ☐ Illness
- ☐ Infection
- ☐ Injury
- ☐ Surgical Procedure
- ☐ Allergy or Drug Sensitivity
- ☐ Other, please explain below:

Home-Space Change - Subquestions

You indicated that you had a change in your home-space or living situation in the last week. What date did the change occur? *(If the change happened on more than one date or over a span of time, please just indicate the date that the changes **started**.)*

◀

October

2021

▶

Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

What kind of change occurred? (Check all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> I have a new computer. | <input type="checkbox"/> Removed old furniture |
| <input type="checkbox"/> I have a new cell phone. | <input type="checkbox"/> Someone moved in with me. |
| <input type="checkbox"/> Home repair or renovation | <input type="checkbox"/> Someone moved out of my home. |
| <input type="checkbox"/> Moved or rearranged existing furniture | <input type="checkbox"/> I moved to a new home. |
| <input type="checkbox"/> Added new furniture | <input type="checkbox"/> Other |

Please briefly describe your repair or renovation:

Is your repair or renovation a temporary home-space change (will it last **less than one month**)?

- ☐ Yes
- ☐ No

Please briefly describe your furniture changes:

Is your furniture change a temporary home-space change (will it last **less than one month**)?

- ☐ Yes
- ☐ No

Who moved in with you?

Is it temporary that someone moved in with you (will it last **less than one month**)?

- ☐ Yes
- ☐ No

Who moved out of your home?

Is it temporary that someone moved out of your home (will it last **less than one month**)?

- ☐ Yes
- ☐ No

What is the address of your new home?

Did you move because you needed more support from caregivers (family members, health care workers, or medication support, for instance) than you could receive in your previous home?

- ☐ Yes
- ☐ No

Is your move out of your home a temporary living situation change (will it last **less than one month**)?

- ☐ Yes
- ☐ No

You indicated "other" - please describe your home-space or living situation change:

Is your "other" home-space or living situation change temporary (will it last **less than one month**)?

- ☐ Yes
- ☐ No

In-Home Assistance

You indicated that you are receiving **new** help with medication management, bathing, dressing or grooming. Please answer the following questions about the new assistance you are receiving.

Who are you now receiving help from?

- ☐ Facility Staff
- ☐ Family Member
- ☐ Private Hire
- ☐ Other, please explain below:

What are you receiving help with? (Check all that apply.)

- ☐ Medication management
- ☐ Bathing, dressing or grooming
- ☐ Other, please explain below:

Will this assistance be temporary, for instance, due to a temporary injury or illness?

- ☐ Yes
- ☐ No
- ☐ I Don't Know

Who initiated this assistance change?

- ☐ Myself
- ☐ Family
- ☐ Retirement Community Staff
- ☐ Doctor
- ☐ Other

Depression - Subquestions

You indicated that you felt **downhearted or blue** for three days or more in the past week. Please briefly describe any specific reasons:

If you have health concerns, are having thoughts of harming yourself, or want to speak to someone about your mood we recommend you contact your primary care physician. You can also contact the National Crisis Call Center Hotline (1-800-273-TALK - if you are a Veteran press Option 1).

Loneliness - Subquestions

You indicated that you felt **lonely** in the past week. Please briefly provide details about your experience:

Completed By

Who completed this survey?

- ☐ I completed this survey about **myself**.
- ☐ I completed this survey on behalf **someone else**.

How are you related to the person you completed the survey for?

- ☐ Partner
- ☐ Family Member
- ☐ Friend
- ☐ Research Assistant
- ☐ Other, please explain:

Please enter the name of the participant you are completing this for:

	First	Last
Name	<input type="text"/>	<input type="text"/>

Please enter the Subject ID of the participant you are completing this form for:

Please enter your initials:

Computer

Technology Use Questionnaire

It is very helpful to us to better understand what kind of technology you use, as many of our studies and questionnaires involve the use of technology. Please respond to the following questions.

Which of the following items do you use? Check all that apply.

- ☐ Desktop Computer
- ☐ Laptop Computer
- ☐ Tablet Computer (iPad, Windows Tablet, etc.)

How long have you been using a computer?

- ☐ Less than 1 year
- ☐ 1-2 years
- ☐ 2-5 years
- ☐ 5 or more years

How would you rate your confidence level when using computers? (In the range below, choose the place on the scale that best reflects your confidence level.)

Total Lack of Confidence ☐ ☐ ☐ ☐ ☐ Extremely Confident

Is your **desktop** computer a PC (Dell, HP, etc.) or an Apple (iMac, etc.)?

- ☐ PC
- ☐ Apple
- ☐ Other, please explain below:

About when did you get this **desktop** computer?

- ☐ Within the last year
- ☐ 1-2 years ago
- ☐ 2-3 years ago
- ☐ 3+ years ago

Is your **laptop** computer a PC (Dell, HP, etc.) or and Apple (Macbook, etc.)?

- ☐ PC
- ☐ Apple
- ☐ Other, please explain below:

About when did you get this **laptop** computer?

- ☐ Within the last year
- ☐ 1-2 years ago
- ☐ 2-3 years ago
- ☐ 3+ years ago

Is your **tablet** computer a PC (Windows Tablet, etc.) or and Apple (iPad, etc.)?

- ☐ PC
- ☐ Apple
- ☐ Other, please explain below:

About when did you get this **tablet** computer?

- ☐ Within the last year
- ☐ 1-2 years ago
- ☐ 2-3 years ago

☐ 3+ years ago

Do you use your **laptop** and/or **tablet** outside of your home or apartment?

- ☐ Yes
- ☐ No
- ☐ I Don't Know

Of your computers, which type do you use the most?

- ☐ Desktop
- ☐ Laptop
- ☐ Tablet

Phone

Which of the following phones do you have? Check all that apply.

- ☐ Landline Telephone
- ☐ Cell Phone

Which one of these best describes the way you use your phone(s)?

- ☐ I only use a landline phone. I do not use a cell phone.



- ☐ I use my landline often, but have a cell phone for emergencies.



- ☐ I use both a landline phone and a cell phone, depending on which one is more convenient.



- ☐ I use my cell phone most of the time, even at home, but I still have a landline that I use occasionally.



- ☐ I don't have a landline phone, I just use a cell phone.



What type of cell phone do you have? Pick the one that looks most like yours.

- ☐ **Flip-Phone**



☐ **Slider-Phone**



☐ **Slider-Phone with Full Keypad**



☐ **Blackberry (Smartphone)**



☐ **iPhone (Smartphone)**



☐ **Droid (Smartphone)**



Does your cell phone have internet access for things like email, maps, web-search, etc.?

- ☐ Yes
- ☐ No
- ☐ I Don't Know.

Do you use your phone to send text messages?

- ☐ Yes
- ☐ No
- ☐ I Don't Know.

If you know it, what is the name of your phone model (e.g. Apple iPhone, HTC One, Motorola Razr, etc.)?

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