

TCARE® Screening Questions

(To be used by Trained TCARE Screeners)

Name

Date

Caregiver ID

Care Receiver Name

1. Are you the person most responsible for caring for your care receiver*?

*Care receiver means any adult who needs care or supervision by an unpaid caregiver. For example, care receiver can be your spouse, partner, parent, adult child, friend, neighbor or other relative.

Yes No

Who do you care for?

- | | | |
|-------------------------------------------------|-----------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Relative Child | <input type="checkbox"/> Other Relative |
| <input type="checkbox"/> Domestic Partner | <input type="checkbox"/> Grandchild | <input type="checkbox"/> Non-Relative |
| <input type="checkbox"/> Ex-Spouse | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Relationship's Missing |
| <input type="checkbox"/> Parent/Parent-in-law | <input type="checkbox"/> Other Elderly Relative | <input type="checkbox"/> Declined to state |
| <input type="checkbox"/> Sibling/Sibling In-Law | <input type="checkbox"/> Other Elderly Non-Relative | <input type="checkbox"/> Other |
| <input type="checkbox"/> Adult Child/In-Law | <input type="checkbox"/> Adult Grandchild | |

REMINDER: Give Caregiver response card

Identity Discrepancy – CR Memory/Placement

2. The following are some thoughts and feelings that people sometimes experience when they assist their care receiver.

As you read through each of the following states indicate the extent to which you agree or disagree with each statement

	Strongly Disagree	Disagree	Disagree a Little	Agree a little	Agree	Strongly Agree	Total
a. The things I am responsible for do not fit very well with what I want to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. I am not sure that I can accept any more responsibility than I have right now.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. I am not always able to be the person I want to be when I am with my care receiver.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. It is difficult for me to accept all the responsibility for my care receiver.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. I am having trouble accepting the way I relate to my care receiver.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. It is difficult for me to accept any more responsibility that I now have to assume.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	(1)	(2)	(3)	(4)	(5)	(6)	

3. Which of the following best describes your care receiver's memory?

- | | |
|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> No Memory Problem | <input type="checkbox"/> Memory or Cognitive Issue Suspected. |
| <input type="checkbox"/> Probable Alzheimer's disease or other dementia is suspected, but is not medically diagnosed. | <input type="checkbox"/> Yes, Alzheimer's disease or other dementia has been medically diagnosed. |

4. Given your care receiver's CURRENT CONDITION, would you consider placing your care receiver in a different care setting?

<input type="checkbox"/> Definitely not	<input type="checkbox"/> Probably would	<input type="checkbox"/> Does not apply-care receiver is in care facility
<input type="checkbox"/> Probably not	<input type="checkbox"/> Definitely would	
Comments		

Burdens/Uplifts

5. As a result of assisting the care receiver, have the following aspects of your life changed?						
<i>As you read through each of the following states indicate the extent to which you agree or disagree with each statement</i>						
<i>Have your caregiving responsibilities...</i>	Not at All	A Little	Moderately	A Lot	A Great Deal	Score
a. Caused conflicts with your care receiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(r)
b. Decreased the time you have to yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(o)
c. Created a feeling of hopelessness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(s)
d. Given your life more meaning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(u)
e. Increased the number of unreasonable requests made by your care receiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(r)
f. Kept you from recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(o)
g. Made you nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(s)
h. Made you more satisfied with your relationship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(u)
i. Caused you to feel that your care receiver makes demands over and above what he/she needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(r)
j. Caused your social life to suffer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(o)
k. Depressed you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(s)
l. Given you a sense of fulfillment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(u)
m. Made you feel you were being taken advantage of by your care receiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(r)
n. Changed your routine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(o)
o. Made you anxious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(s)
p. Left you feeling good?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(u)
q. Increased attempts by your care receiver to manipulate you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(r)
r. Given you little time for friends and relatives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(o)
s. Caused you to worry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(s)
t. Made you enjoy being with your care receiver more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(u)
u. Left you with almost no time to relax?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(o)
v. Made you cherish your time with your care receiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(u)
	(1)	(2)	(3)	(4)	(5)	
Totals	Relationship		Objective	Stress		Uplift
Comments:						

Depression

6. Now I am going to read you a list of statements about the way you have felt in the past week.

For each statement that I read tell me how often you have felt this way in the past week.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or moderate amount of time (3-4 days)	All of the time (5-7 days)	Total
a. I was bothered by things that usually don't bother me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. I had trouble keeping my mind on what I was doing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. I felt depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. I felt that everything I did was an effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. I felt hopeful about the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	(4)	(3)	(2)	(1)	
f. I felt fearful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. My sleep was restless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
h. I was happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	(4)	(3)	(2)	(1)	
i. I felt lonely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
j. I could not "get going."	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	(1)	(2)	(3)	(4)	

Comments

Screening Summary

7. Assessment Location

- | | | |
|---------------------------------------------|-------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Self-screening | <input type="checkbox"/> In-Home (online) | <input type="checkbox"/> Over the Phone |
| <input type="checkbox"/> In-Home (on paper) | <input type="checkbox"/> In office | <input type="checkbox"/> Other |

8. Is the caregiver paid to provide the care receiver with care?

- Yes No

Comments