

Participant ID: \_ \_ \_ \_

<b>1. What is your age (in years)?</b>  _____	<b>2. What is your sex?</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer
<b>3. What is your yearly household income?</b> <input type="checkbox"/> Less than \$50,000 <input type="checkbox"/> From \$50,000 to \$99,999 <input type="checkbox"/> From \$100,000 to \$149,999 <input type="checkbox"/> From \$150,000 to \$199,999 <input type="checkbox"/> From \$200,000 to \$249,999 <input type="checkbox"/> More than \$250,000	<b>4. What is your race/ethnicity? Please check <u>all</u> that apply.</b> <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black or African-American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other _____
<b>5. What is your employment status?</b> <input type="checkbox"/> Full-time employed <input type="checkbox"/> Part-time employed <input type="checkbox"/> Retired <input type="checkbox"/> No work outside the home <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Student	<b>6. What is the highest level of education you have achieved?</b> <input type="checkbox"/> Less than high school <input type="checkbox"/> High school graduate <input type="checkbox"/> 2-year college degree <input type="checkbox"/> 4-year college degree <input type="checkbox"/> Post-college graduate degree
<b>7. What is your relationship status?</b> <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Single, never married <input type="checkbox"/> Single, divorced, or separated <input type="checkbox"/> Single, widowed	<b>8. What type of insurance do you have? If multiple, please check your <u>primary</u>.</b> <input type="checkbox"/> Medicaid/Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Private/Commercial Health Insurance <input type="checkbox"/> No health insurance

1. Thinking about the reason you are in the clinic for this time, do you feel that you delayed seeing a doctor or other medical person longer than you should have?  
 Yes                       No
2. If yes, what was the principal reason?  
 Could not get an appointment  
 Cost too much  
 Did not have time  
 Thought problem would go away or was not serious enough  
 Other, please specify \_\_\_\_\_
3. In the last 12 months, have you put off, postponed, or skipped seeing a doctor due to cost when you were sick or injured?  
 Yes                       No
4. In the last 12 months, have you skipped a recommended medical test or treatment due to cost?  
 Yes                       No

Please return to Kamal/Yao research team.

**Instructions:** Below is a list of statements that patients have said are important. Please *circle or mark one number per line to indicate your response as it applies to the past 7 days*.

		Not at all	A little bit	Some-what	Quite a bit	Very much
1.	I know that I have enough money in savings, retirement, or assets to cover the costs of my treatment.	0	1	2	3	4
2.	My out-of-pocket medical expenses are more than I thought they would be.	0	1	2	3	4
3.	I worry about the financial problems I will have in the future as a result of my illness or treatment.	0	1	2	3	4
4.	I feel I have no choice about the amount of money I spend on care.	0	1	2	3	4
5.	I am frustrated that I cannot work or contribute as much as I usually do.	0	1	2	3	4
6.	I am satisfied with my current financial situation.	0	1	2	3	4
7.	I am able to meet my monthly expenses.	0	1	2	3	4
8.	I feel financially stressed.	0	1	2	3	4
9.	I am concerned about keeping my job and income, including work at home.	0	1	2	3	4
10.	My illness or treatment has reduced my satisfaction with my present financial situation.	0	1	2	3	4
11.	I feel in control of my financial situation.	0	1	2	3	4

Everyone experiences painful situations at some point in their lives. Such experiences 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.

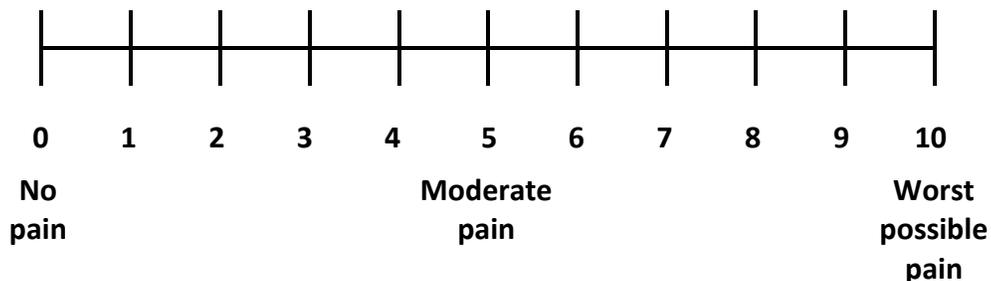
We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when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

		Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
1.	I worry all the time about whether the pain will end.	0	1	2	3	4

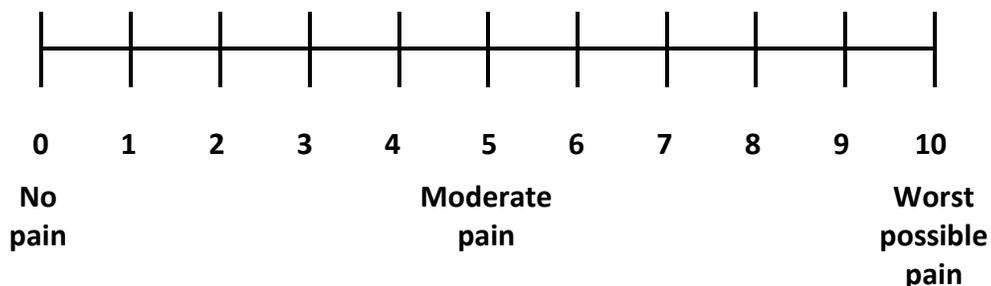
Please return to Kamal/Yao research team.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
2. I feel I can't go on.	0	1	2	3	4
3. It's terrible and I think it's never going to get any better.	0	1	2	3	4
4. It's awful and I feel that it overwhelms me.	0	1	2	3	4
5. I feel I can't stand it anymore.	0	1	2	3	4
6. I become afraid that the pain will get worse.	0	1	2	3	4
7. I keep thinking of other painful events.	0	1	2	3	4
8. I anxiously want the pain to go away.	0	1	2	3	4
9. I can't seem to keep it out of my mind.	0	1	2	3	4
10. I keep thinking about how much it hurts.	0	1	2	3	4
11. I keep thinking about how badly I want the pain to stop.	0	1	2	3	4
12. There's nothing I can do to reduce the intensity of the pain.	0	1	2	3	4
13. I wonder whether something serious may happen.	0	1	2	3	4

1. Please select the number that best represents your **current pain intensity** on a 0-to-10 scale where 0 = no pain and 10 = worst possible pain.

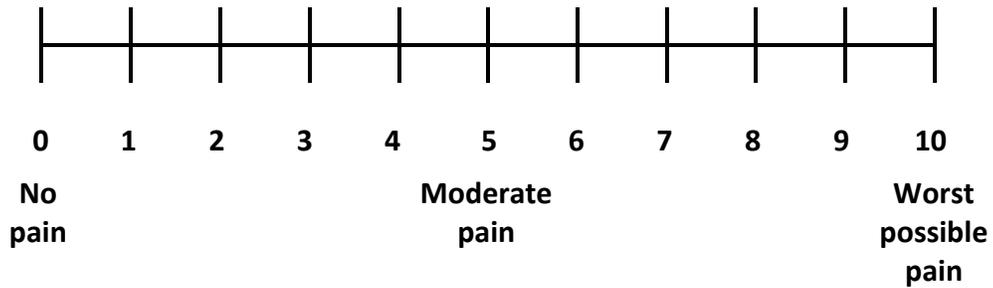


2. Please select the number that best represents the **least intensity** of your pain in the **past 7 days** on a 0-to-10 scale where 0 = no pain and 10 = worst possible pain.

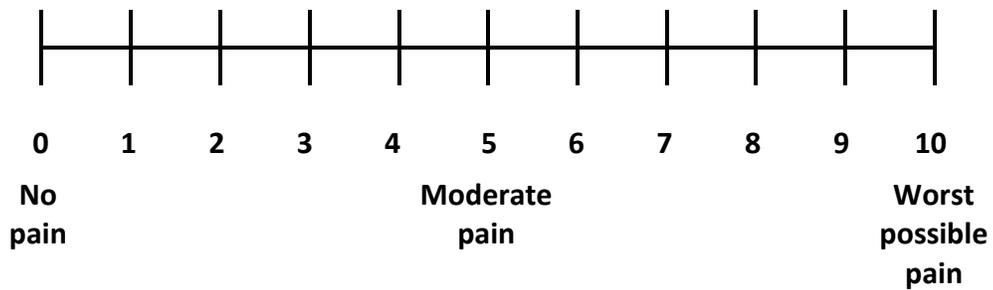


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3. Please select the number that best represents the **worst intensity** of your pain in the **past 7 days** on a 0-to-10 scale where 0 = no pain and 10 = worst possible pain.



4. Please select the number that best represents the **average intensity** of your pain in the **past 7 days** on a 0-to-10 scale where 0 = no pain and 10 = worst possible pain.



**Thank you for completing this survey!**