

Family Reported Outcome Measure (FROM-16)[©]

Confidential

The following questions are about how **your** life is being affected by your family member's condition **at this time**.

Please check one box for each of the 16 questions.

Please answer the following questions:

Your age: _____

Your gender: Male / Female

Your relationship to the patient: _____

Patient's diagnosis: _____

Part 1: Emotional

Because of my family member's condition...

Not at all A little A lot

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 1. I feel worried | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I feel angry | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I feel sad | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I feel frustrated | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. It is difficult to find someone to talk to about my thoughts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Caring for my family member is difficult | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Part 2: Personal and Social Life

Because of my family member's condition...

Not at all A little A lot

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 7. It is hard to find time for myself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. My every day travel is affected | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. My eating habits are affected | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. My family activities are affected | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. I experience problems with going on vacation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. My sex life is affected | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. My work or study is affected | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. My relationships with other family members are affected | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. My family expenses are increased | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. My sleep is affected | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please check that you have answered all the questions. Thank you.

For office use only Score for part 1 (out of 12): _____ Score for part 2 (out of 20): _____ Total score (out of 32): _____