

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): _____