



Information Sheet

You are invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like more information, please contact the Researcher carrying out the Project. Her details are available at the end of the information sheet.

What is the research study about?

Currently there is very little research available regarding the well-being of individuals who work on their own and away from a work or a home base for the majority of their working time. Such workers include Sales Representatives, Delivery Drivers, and Technical Staff who are isolated and working remotely “on the road” for different operational reasons, as well as many other different jobs.

As a group of workers, there is little information available to identify the impact on individuals who have minimal face-to-face contact with their managers or colleagues. This study intends to find out what the exact areas of concerns may be for this group of workers using a two-stage approach. Firstly, a series of fact-finding interviews will be carried out with a cross-section of remote and isolated workers. Secondly, information obtained from the interviews will be used to develop a large-scale questionnaire survey to identify the psychological, physical and operational factors that affect people who work remotely and on their own.

Who is taking part in the study?

This stage of the study involves a questionnaire survey of participants who work away from a work or home base for the majority of their working week. We are asking a cross-section of individuals in a variety of jobs to take part in this survey to identify what issues remote and isolated working may present to them. This is an anonymous and confidential questionnaire to identify if there are particular work or health issues for the individual, the equipment used by people in their working day and what benefits there are in this type of work. All questionnaires will be returned directly to the research team.

What are the benefits?

The study will identify factors relevant to remote working including health, safety, ergonomics, the home/work interface and psychosocial well being. Benefits from this study will be clear recommendations for the development of policies for managing remote and isolated workforces.

What are the risks?

The researchers do not see any risk to individual participants taking part in this study and we therefore state it to be a “minimal risk” study.

What are the alternatives?

There are two main alternatives in the study, firstly that the study is not carried out at all. Consequently there will be no further knowledge generated about remote and isolated workers. Secondly, participants could be interviewed. The study would take much longer to carry out, confidentiality issues would be raised by this method and it may not produce results from a wide cross-section of workers.

What if I do not want to take part?

It is up to you to decide whether to take part in the study or not. If you do decide to take part in the survey then please keep this information sheet. We would like you to complete the attached questionnaire. We do not ask participants to sign a consent form, as we want to maintain your anonymity and confidentiality. If you do decide to take part, you are free to withdraw at any time without giving a reason.

What happens to the information?

Each questionnaire will remain confidential and no identifying information is included on it. Only the research team will see any interview data. Before any data reaches the public domain, it will be anonymised and summarised. This means that no individual details will be known.

What happens now if I decide to take part

If you agree to take part, we would like you to complete the enclosed questionnaire. This will take approximately 15 minutes to complete on your own and in privacy.

Who is funding and organising the research?

The research has been funded by the British Occupational Health Research Foundation (BOHRF) and carried out by the Institute of Occupational and Environmental Medicine, Division of Primary Care, Public and Occupational Health, School of Medicine, The University of Birmingham. The BOHRF have evaluated the methods we wish to use and support the work and the methodology we have proposed.

Further information/clarification

If you have any further queries regarding the research you can contact the Principal Investigator of the research team between normal office hours, 9.00 am to 5.00 pm, or outside these hours there is an answer phone. The contact details are below.

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Thank you for reading the information



The IOM is carrying out research into the health and well being at work of mobile workers. This questionnaire asks you about aspects of your health, the type of work you do and the vehicles and equipment you use at work. It is essential to the success of the research that as many people respond to the questionnaire as possible, and we are grateful for your participation.

The questionnaire is made up of a number of validated scales and you are asked to complete each question by circling or ticking the relevant answer. It is important that you attempt to answer all questions. The questionnaire has been designed to protect your anonymity and to ensure the results remain confidential to the research team. Before any data reaches the public domain it will be anonymised and summarised.

Please return the completed questionnaire directly to the research team in the reply-paid envelope enclosed.

There are two types of question found on the questionnaire, and examples of these are shown below:

Example 1. (ring the appropriate response)

Been feeling well and in good health?

Better than usual	Same as usual	Worse than usual	Much worse than usual
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Example 2. (tick the appropriate response)

	Never or almost never	3 or 4 times per year	Once a month	Once a week	More than once per week
Eyes water	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy eyes or skin	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION A: About how your health has been of late and how you feel

We would like to know if you have had any medical complaints and how your health has been in general, over the last few weeks. Please answer all the questions by circling the answer which best applies to you. Remember that we want to know about present and recent complaints, not those that you have had in the past

1. Have you recently . . .

Been feeling well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
Been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been getting pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been getting a feeling of tightness or pressure in the head?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual

2. Have you also recently . . .

Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
Had difficulty staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been edgy and bad tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been getting scared and panicky for no good reason ?	Not at all	No more than usual	Rather more than usual	Much more than usual
Found everything getting on top of you ?	Not at all	No more than usual	Rather more than usual	Much more than usual
Been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual

3. Have you recently . . .

Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
Been taking longer over things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
Felt on the whole you were doing things well?	Better than usual	About the same	Less than usual	Much Less Well
Been satisfied with the way you carry out a task?	More satisfied	Same as usual	Less than usual	Much less capable
Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less so than usual	Much less useful
Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual

Although the last questions are personal, it is important that you answer them to allow the questionnaire to be analysed fully.

4. Have you recently...

Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
Felt that life is not worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
Thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
Found at times you couldn't do anything because your nerves were so bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
Found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
Found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely have

If you any of these questions have upset you or made you concerned about how you feel at present, you could get help from your own GP, from your Occupational Health department, or by contacting Dr Joanne Crawford who is running this research project

SECTION B: Common symptoms

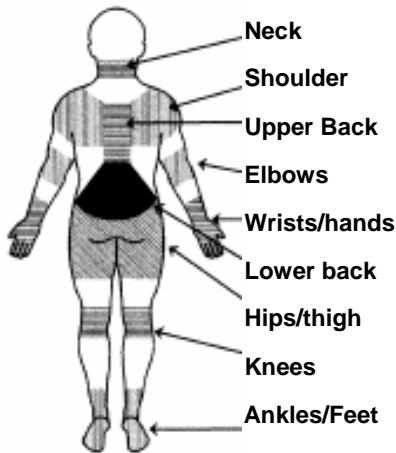
Several common symptoms or bodily sensations are listed below. Many people have experienced most of them at one time or another. We are interested in finding out how common each symptom is among mobile workers.

5. Please show how frequently you experience each symptom below by ticking the most relevant box.

	Never or almost never	3 or 4 times per year	Once a month	Once a week	More than once per week
Eyes water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy eyes or skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temporary deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lump in throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choking sensations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congested nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Racing heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands / feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toothaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upset stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiff or sore muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never or almost never	3 or 4 times per year	Once a month	Once a week	More than once per week
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling pressure in head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel faint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any numbness / tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twitching of eyelid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twitching other than eyelid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands tremble or shake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiff joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sunburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive or tender skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Face flushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin breaks out in rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne or pimples on face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne / pimples other than face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweat even in cold weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong reactions to insect bites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haemorrhoids / Piles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION C: Musculoskeletal Health



In this picture you can see the approximate position of the parts of the body referred to in the questionnaire. The tables below ask about any pains you have had in those body-areas.

Please answer by ticking the appropriate box for each body-area. You may be in doubt as to how to answer, but please do your best anyway.

Note that the questionnaire is to be completed even if you have never had trouble in any part of your body.

6. In the last 12 months, have you . . .

	Had trouble e.g. ache, pain, or discomfort		Been prevented from carrying out normal activities		Seen a nurse, doctor or physio because of:		How many days trouble have you had in the last 12 months	
	No	Yes	No	Yes	No	Yes	(please tick)	
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days	<input type="checkbox"/> 8-28 days
							<input type="checkbox"/> 30 days plus	<input type="checkbox"/> every day
Shoulders <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days	<input type="checkbox"/> 8-28 days
							<input type="checkbox"/> 30 days plus	<input type="checkbox"/> every day
Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days	<input type="checkbox"/> 8-28 days
							<input type="checkbox"/> 30 days plus	<input type="checkbox"/> every day
Elbows <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days	<input type="checkbox"/> 8-28 days
							<input type="checkbox"/> 30 days plus	<input type="checkbox"/> every day
Wrists / Hands <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days	<input type="checkbox"/> 8-28 days
							<input type="checkbox"/> 30 days plus	<input type="checkbox"/> every day
Lower Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days	<input type="checkbox"/> 8-28 days
							<input type="checkbox"/> 30 days plus	<input type="checkbox"/> every day
Hips / Thighs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days	<input type="checkbox"/> 8-28 days
							<input type="checkbox"/> 30 days plus	<input type="checkbox"/> every day
Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days	<input type="checkbox"/> 8-28 days
							<input type="checkbox"/> 30 days plus	<input type="checkbox"/> every day
Ankles / Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days	<input type="checkbox"/> 8-28 days
							<input type="checkbox"/> 30 days plus	<input type="checkbox"/> every day

7. Have you ever . . .

	Injured this body-part through an accident		Needed to change jobs / duties because of pain		Needed to cut down activity at home because of pain		How many days have you been unable to work because of pain in the last 12 months	
	No	Yes	No	Yes	No	Yes	No	Yes
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days <input type="checkbox"/> 30 days plus	<input type="checkbox"/> 8-28 days <input type="checkbox"/> every day
Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days <input type="checkbox"/> 30 days plus	<input type="checkbox"/> 8-28 days <input type="checkbox"/> every day
Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days <input type="checkbox"/> 30 days plus	<input type="checkbox"/> 8-28 days <input type="checkbox"/> every day
Elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days <input type="checkbox"/> 30 days plus	<input type="checkbox"/> 8-28 days <input type="checkbox"/> every day
Wrists / Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days <input type="checkbox"/> 30 days plus	<input type="checkbox"/> 8-28 days <input type="checkbox"/> every day
Lower Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days <input type="checkbox"/> 30 days plus	<input type="checkbox"/> 8-28 days <input type="checkbox"/> every day
Hips / Thighs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days <input type="checkbox"/> 30 days plus	<input type="checkbox"/> 8-28 days <input type="checkbox"/> every day
Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days <input type="checkbox"/> 30 days plus	<input type="checkbox"/> 8-28 days <input type="checkbox"/> every day
Ankles / Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1-7 days <input type="checkbox"/> 30 days plus	<input type="checkbox"/> 8-28 days <input type="checkbox"/> every day

8. In the past 7 days, have you ever.....

	Had trouble e.g., ache, pain or discomfort	
	No	Yes
Neck	<input type="checkbox"/>	<input type="checkbox"/>
Shoulders <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back	<input type="checkbox"/>	<input type="checkbox"/>
Elbows <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/>	<input type="checkbox"/>
Wrists / Hands <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back	<input type="checkbox"/>	<input type="checkbox"/>
Hips / Thighs	<input type="checkbox"/>	<input type="checkbox"/>
Knees	<input type="checkbox"/>	<input type="checkbox"/>
Ankles / Feet	<input type="checkbox"/>	<input type="checkbox"/>

SECTION D: Fatigue

The following questions are designed to measure if you have been feeling tired, fatigued, or had a general feeling of being 'run-down' over the last few weeks.

9. Please complete all of the questions as accurately and as clearly as you can by circling the response that is the most appropriate to you for each question.

Do you have problems with tiredness?	Less than usual	No more than usual	More than usual	Much more than usual
Do you need to rest more?	Less than usual	No more than usual	More than usual	Much more than usual
Do you feel sleepy or drowsy?	Less than usual	No more than usual	More than usual	Much more than usual
Do you have problems starting things?	Less than usual	No more than usual	More than usual	Much more than usual
How energetic do you feel?	Much more energetic than usual	More energetic than usual	No more energetic than usual	Less energetic than usual
How much strength do you have in your muscles?	Much more strength than usual	More strength than usual	No more strength than usual	Less strength than usual
Do you feel weak?	Less weak than usual	Same as usual	More weakness than usual	Much more weakness than usual
Do you have difficulty concentrating?	Less difficult than usual	No more difficult than usual	More difficult than usual	Much more difficult than usual
Do you make slips of the tongue when speaking?	Less slips than usual	No more slips than usual	More slips than usual	Much more slips than usual
Do you find it difficult to find the correct word?	Less difficult than usual	No more difficult than usual	More difficult than usual	Much more difficult than usual
How is your memory?	Better than usual	No worse than usual	Worse than usual	Much worse than usual

SECTION E: General well-being

10. The following questions assess your current opinion with regard to yourself and those around you.

	Very good	Good	Neither good nor bad	Bad	Very bad
How has your physical health been lately?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How do you consider your mental health at the moment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How do you feel about yourself at the moment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How are your relationships with your friends at the moment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where applicable, how is your relationship with your partner at the moment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION F: About you

11. Are you: Male Female
12. What is your date of birth? Day Month Year
13. Have you ever smoked as much as one cigarette a day (or one cigar a week or an ounce of tobacco a month) for as long as a year? Yes No
14. Do you smoke now? Yes No

SECTION G: About your job

15. What is your current job title? _____
16. What company do you work for? _____
17. What region (county) do you work in? _____
18. How long have you been in your current job? years months
19. How long have you been a mobile worker? years months
20. How many hours are you contracted to work per week? hours
21. How many hours do you actually work per week? hours

22. How many hours do you spend at a home or office base in a typical week? hours

23. What times do you work? (please tick the one that applies best)

Day shift Night shift Rotating shifts

Other (please describe) _____

24. How many times do you have contact with your line manager in a typical week? times

25. How is contact made with your manager? (please tick all that apply)

Face-to-face Mobile phone E-mail None

Voice mail

Other (please describe) _____

26. How many times do you have contact with your colleagues in a typical week? times

27. How is this contact with colleagues made? (please tick all that apply)

Face-to-face Mobile phone E-mail

Voice mail

Other (please describe) _____

SECTION H: About your vehicle and driving

28. What type of vehicle do you drive at work? (please tick all that apply)

Saloon car Hatchback Estate car

Small Van Transit van Lorry

Other (please describe) _____

29. How many hours do you spend driving in a typical week? hours

30. What is your average mileage in a typical week? miles

31. Are you comfortable when driving? Yes No

32. Can you adjust the seat in the vehicle to sit comfortably? Yes No

33. How many hours do you spend working in your vehicle per week? hours

34. Do you have any discomfort issues when working in your vehicle? Yes No

35. What equipment do you use in your vehicle? (Please tick all that apply)

Laptop Blackberry Sat Nav

Mobile phone PDA

Other (please describe) _____

36. If "No", where do you principally work in your vehicle (please tick the one that applies)

Driver's seat Rear seats Passenger seat

Other (please describe) _____

37. Which emergency equipment do you routinely carry in your vehicle (Please tick all that apply)

Drinking water Irrigation water Blankets Flares Shovel

Flashlight Map Batteries

Other (please describe) _____

38. Have you ever been the victim of "Road Rage"? Yes No

39. If "Yes" – how many times have you been subjected to Road Ragewhile working? times

40. Have you ever been the victim of assault while on the road or working? Yes No

41. If "Yes" - How many times have you been assaulted while on the road or working? times

42. Have you had equipment stolen from your vehicle while on the road? Yes No

43. If "Yes" - How many times have you had things stolen while on the road? times

44. Please rate the following statements by ticking the relevant box.

Always Sometimes Never

Are rest breaks scheduled into your working day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to take rest breaks during your working day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have access to healthy food during your working day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to choose where you work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to choose at what times you work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you easily access information about safety at work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any concerns about personal safety at work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you easily access occupational health at work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you easily access training programmes at work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where applicable, do you have sufficient time for family life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is it easy to balance work and family life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your work have a positive impact on family life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have freedom to choose how you do your tasks on a daily basis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have to make decisions without consulting your manager?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel you need to consult with your manager before making important decisions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that your managers are checking up on you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have any additional comments please add them in the box below

Please return the questionnaire to the research team in the freepost envelope provided

Thank you for your help and your time

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