



Glasgow Outcome Scale Questionnaire (GOSE-Postal) - English Version

These questions are to do with changes in your lifestyle since your injury. There are also some questions about how things were before the injury. The questions can be answered by you, or by a close relative or friend, or by you both together. We are interested in the recovery you have made up to now.

Injured person's name _____ Today's date _____

Person who filled out this form

Patient alone Relative or friend or carer alone
Patient and relative, friend or carer together

The injured person is

Out of hospital In hospital or residential care

Please answer each question by ticking one box which is true for you.

1. Before the injury were you able to look after yourself at home? Yes No

2. As a result of your injury do you now need someone to help look after you at home?
(please tick one box)

- I do not need help or supervision in the home
- I need some help in the home, but not every day
- I need help in the home every day, but I could look after myself for at least 8 hours if necessary
- I could not look after myself for 8 hours during the day
- I need help in the home, but not because of the injury

3. Before the injury were you able to buy things at shops without help? Yes No

4. As a result of your injury do you now need help to buy things at shops? (please tick one box)

- I do not need help to shop
 - I need some help, but I can go to local shops on my own
 - I need help to shop even locally, or I cannot shop at all
 - I need help to shop, but not because of the injury
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5. Before the injury were you able to travel without help? Yes No

6. As a result of your injury do you now need help to travel? (please tick one box)

- I do not need help to travel
I need some help, but can travel locally on my own (e.g. by arranging a taxi)
I need help to travel even locally, or I cannot travel at all
I need help to travel but not because of the injury
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7. Employment before the injury (please tick one box)

- Working Looking for work
Looking after family Studying as a student
Retired None of these (e.g. unfit for work)

8. As a result of your injury has there been a change in your ability to work? (or to study if you were a student; or to look after your family) (please tick one box)

- I still do the same work
I still do the same work, but have some problems (e.g. tiredness, lack of concentration)
I still work, but at a reduced level (e.g. change from full-time to part-time, or change in level of responsibility)
I am unable to work, or only able to work in sheltered workshop
My ability to work has changed, but not because of the injury
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9. Before the injury did you take part in regular social and leisure activities outside home (at least once a week)? Yes No

Social and leisure activities include: going out to a pub or club, visiting friends, going to the cinema or bingo, going out for a walk, attending a football match, taking part in sport.

10. As a result of your injury has there been a change in your ability to take part in social and leisure activities outside home? (please tick one box)

- I take part about as often as before (the activities may be different from before)
I take part a bit less, but at least half as often
I take part much less, less than half as often
I do not take part at all
My ability to take part has changed for some other reason, not because of the injury

11. Before the injury did you have any problems in getting on with friends or relatives? Yes No

12. As a result of your injury are there now problems in how you get on with friends or relatives? (please tick one box)

- Things are still much the same
There are occasional problems (less than once a week)
There are frequent problems (once a week or more)
There are constant problems (problems every day)
There are problems for some other reason, not because of the injury

13. Are there any other problems resulting from your injury which have interfered with your daily life over the past week? (Problems sometimes reported after head injury: headaches, dizziness, tiredness, sensitivity to noise or light, slowness, memory failures, and concentration problems.) (please tick one box)

- I have no current problems
I have some problems, but these do not interfere with my daily life
I have some problems, and these have affected my daily life
I have some problems for other reasons, not because of the head injury

14. Before the injury were similar problems present? (please tick one box)

- I had no problems before, I had minor problems
I had similar problems before

Are there any other comments that you would like to make?
(Please continue overleaf if you wish)