



Lifestyle Questionnaire

(Revised in consultation with ex-service organisations)

You should only complete this form if you want the Department of Veterans' Affairs to assess a lifestyle rating for you based on the information you provide.

Assessing your lifestyle

It is important to remember that when reporting on your lifestyle you should describe only the effects of disabilities which

- have been accepted by the Commission as war/defence caused; and/or
- are the subject of your present claim or application for increase.

The effects of any disabilities which have not been accepted as war/defence caused, will not be taken into account in assessing your lifestyle rating.

Completing this form

This form is in 5 parts and asks for details about your:

PART A - personal details.

PART B - personal relationships.

PART C - mobility.

PART D - recreation and community activities.

PART E - domestic and employment activities.

Only answer the questions that you consider apply to your accepted or newly claimed disabilities. You are not obliged to answer questions you do not want to, or questions that are not relevant to you.

Assistance in completing this form

You may wish to discuss your lifestyle with your spouse, other family members or a friend. It may be in your interest to talk to an ex-service organisation welfare officer or other qualified person.

Assistance from DVA

DVA staff can also help to complete this form.

Privacy Notice

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by the Department of Veterans' Affairs (DVA) for the delivery of government programs for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants.

[Read more: How DVA manages personal information](#)

For information, please call the Department of Veterans' Affairs (from anywhere in Australia) on:

1800 VETERAN (1800 838 372)

| State | Address | Postal address |
|------------------------------|---|-----------------------------------|
| New South Wales | Centennial Plaza Tower B 280 Elizabeth Street Sydney NSW 2001 | GPO Box 9998 Brisbane QLD 4001 |
| Victoria | 300 La Trobe Street Melbourne VIC 3000 | GPO Box 9998 Brisbane QLD 4001 |
| Queensland | 480 Queen Street Brisbane QLD 4000 | GPO Box 9998 Brisbane QLD 4001 |
| South Australia | Blackburn House 199 Grenfell Street Adelaide SA 5000 | GPO Box 9998 Brisbane QLD 4001 |
| Western Australia | AMP Building 140 St Georges Terrace Perth WA 6000 | GPO Box 9998 Brisbane QLD 4001 |
| Tasmania | Barrack Place 254 - 286 Liverpool Street Hobart TAS 7001 | GPO Box 9998 Brisbane QLD 4001 |
| Northern Territory | Winnellie Central 14 Winnellie Road Winnellie NT 0820 | GPO Box 9998 Brisbane QLD 4001 |
| Australian Capital Territory | 6 Bowes Street Woden ACT 2606 | GPO Box 9998 Brisbane QLD 4001 |

PART A**Personal details****1 Your surname****2 Given name(s)****3 Date of birth****4 DVA file number or your service number****5 Your signature**

Date

PART B**Personal relationships**

This concerns how well you get on with other people

6 Which of the following statements apply to you?

(You may tick more than one box).

Your personal relationships are unaffected by your disabilities ☐You are sometimes tense and a little anxious but still get on well with most people most of the time ☐You are often tense and irritable but still get on with some people fairly well ☐You don't sleep well ☐You often get cranky with pain ☐You find it difficult to discuss your problems ☐You are moody and irritable most of the time and usually find it difficult to get on with people ☐You are withdrawn and find it difficult to get on with other people ☐You have to depend on other people a lot ☐Your life is completely ruined ☐**7 How do you believe that your disabilities cause the above problems?**

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8 Do your disabilities affect your life with your family?

No ☐

Yes ☐ ► Please describe in what way

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9 Do your disabilities affect your social life?

No ☐

Yes ☐ ► Please describe in what way

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10 Has there been a change in the way you get on with other people since the disabilities occurred (or got worse)?

No ☐

Yes ☐ ► Please describe in what way

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This question is optional. You do not need to answer it if you do not wish to.

11 Do your disabilities affect your sexual feelings or abilities?

No ☐

Sometimes ☐

Yes ☐

Affected by medication and/or treatment ☐

You may describe if you wish

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12 Does your medication affect your family or social life?

No ☐

Yes ☐ ► Please describe in what way

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PART C**Mobility**

This means your ability to move around in your usual surroundings. Your usual surroundings include your home that you usually visit. For example, church, shops, friends' houses.

It also includes your ability to use public transport or private cars to reach these locations and places.

13 Do you have any problems walking?

(Types of problems you may have affecting your mobility could include shortness of breath, or pain etc.)

No ☐Yes ☐ ► Please give details below

| Type of problem | How often it occurs (please tick) | |
|--------------------------|--|---|
| 1. <div></div> | All the time <input type="checkbox"/> | Some of the time <input type="checkbox"/> |
| | Most of the time <input type="checkbox"/> | Hardly ever <input type="checkbox"/> |
| | Depends on what I do and how fast I do it <input type="checkbox"/> | |
| 2. <div></div> | All the time <input type="checkbox"/> | Some of the time <input type="checkbox"/> |
| | Most of the time <input type="checkbox"/> | Hardly ever <input type="checkbox"/> |
| | Depends on what I do and how fast I do it <input type="checkbox"/> | |
| 3. <div></div> | All the time <input type="checkbox"/> | Some of the time <input type="checkbox"/> |
| | Most of the time <input type="checkbox"/> | Hardly ever <input type="checkbox"/> |
| | Depends on what I do and how fast I do it <input type="checkbox"/> | |
| 4. <div></div> | All the time <input type="checkbox"/> | Some of the time <input type="checkbox"/> |
| | Most of the time <input type="checkbox"/> | Hardly ever <input type="checkbox"/> |
| | Depends on what I do and how fast I do it <input type="checkbox"/> | |
| 5. <div></div> | All the time <input type="checkbox"/> | Some of the time <input type="checkbox"/> |
| | Most of the time <input type="checkbox"/> | Hardly ever <input type="checkbox"/> |
| | Depends on what I do and how fast I do it <input type="checkbox"/> | |

14 Do you need something to help you move around (crutches, wheelchair etc.)?No ☐Yes ☐ ► What do you use?

How often do you use the device?

All of the time ☐Only sometimes ☐**15 Do you need fittings in your house to assist mobility?**No ☐Yes ☐ ► Please describe in what way

16 Do you need someone to help you move around or to go with you?

No ☐

Yes ☐ ► What type of help do you need?

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17 Are there any restrictions on your ability to sit in, or drive a car?

No ☐

Yes ☐ ► Please describe the restrictions

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18 Are there any forms of transport which you normally use, but have difficulty using?

No ☐

Yes ☐ ► What forms of transport?

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What difficulties do you have using the transport?

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How often do the difficulties occur?

All of the time ☐

Only sometimes ☐

PART D**Recreation and community activities**

This concerns your ability to take part in social activities.

19 How often do you do the following things?

| | A lot every day | A little every day | 2 or 3 times weekly | Monthly | Rarely or never | Weekly or fortnightly |
|--|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|--------------------------|
| Visit or have visitors (e.g. friends or relatives) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Go out (e.g. to church, to watch sport, for entertainment, for meals or walks) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Play a sport (e.g. golf, tennis, bowls, fishing) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do a hobby (e.g. craft, music, art, stamp collecting, cards, woodwork) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Relax (e.g. reading, watching TV, listening to music) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do voluntary work (e.g. meals on wheels, welfare officer at RSL, Legacy) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

20 Do you have difficulty doing any other activities because of your disabilities?No ☐Yes ☐ ► Please describe the difficulties

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21 Are there any activities you have given up because of your disabilities?No ☐Yes ☐ ► What are the activities?

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PART E**Domestic and employment activities**

This concerns your ability to carry out common household tasks and your ability to work.

DOMESTIC ACTIVITIES**22 How well can you do the following things?**

| | Easily | With difficulty | With help | If I take my time | I can't do it | I don't need to | Not applicable |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Grocery shopping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| House cleaning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Washing up | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Minor house repairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Light gardening such as weeding and watering | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heavy gardening such as digging and pruning trees | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lawn mowing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Washing the car | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cooking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sewing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Knitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

23 Are there any domestic activities you have stopped doing because of your disabilities?No ☐Yes ☐ ► What are the activities?

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24 Are there any domestic activities which you have difficulty doing or take you longer than they used to?

No ☐

Yes ☐ ► Please describe the difficulties

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25 Does someone do things for you that you used to do?

No ☐

Yes ☐ ► Please describe these things

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EMPLOYMENT ACTIVITIES

26 Are you employed?

No ☐ ► Go to Question **36**

Yes ☐

27 What is your occupation?

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28 Is your employment full-time, part-time or casual?

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29 How many hours per week do you normally work?

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30 Have you changed jobs in the last 5 years?

No ☐

Yes ☐ ► Why did you change jobs?

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31 Are there things you can't do at work that you used to do?

No ☐

Yes ☐ ► What things can't you do?

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Why are you unable to do them?

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EMPLOYMENT ACTIVITIES *continued..*

32 Have you changed your workplace or the way you work to make it easier?

No ☐

Yes ☐ ► What changes have you made?

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Why did you make these changes?

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33 Have you changed the hours you normally work?

No ☐

Yes ☐ ► Why did you change the hours

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34 Have you lost any time from work during the past 12 months because of your disabilities?

No ☐

Yes ☐ ► How much time have you lost?

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35 In your opinion, have your disabilities affected your future or career?

No ☐ ► If you have not stopped working go to Question **40**, otherwise go to next Question

Yes ☐ ► Please describe in what way

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► If you have not stopped working go to Question **40**, otherwise go to next Question

IF YOU HAVE STOPPED WORKING..

36 What year did you stop working?

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37 Why did you stop working?

Age ☐

Ill-health ☐

Other ☐ ► Please give reasons

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No ☐

Yes ☐ ► Please describe in what way

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No ☐ ► Go to Question **40**

Yes ☐ ► Will your disabilities have any effect on your chance of employment?

No ☐

Yes ☐ ► Please describe in what way

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In this section you can put in your own words the effect your disabilities have on your lifestyle.

[illegible]

Use this space if you would like to tell us further details about the effect your disabilities have on your lifestyle.

[illegible]