Quality of life and self-perception of health of patients from an Outpatient Clinic of Speech-Language Pathology and Audiology

Autopercepção de saúde e qualidade de vida de pacientes de um Ambulatório de Fonoaudiologia

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ABSTRACT

Purpose: To evaluate the overall quality of life of adults undergoing speech-language therapy, using the WHOQOL-Bref; to investigate the self-perception and the concept of health of these individuals. **Methods:** Two questionnaires were applied to 97 adult patients from an Outpatient Clinic of Speech-Language Pathology and Audiology: the Instrument of Investigation on the Perception of Health, composed of open and closed questions, and the WHOQOL-Bref. Content analysis was used to analyze open questions, and the scores were statistically analyzed. **Results:** The highest score on the WHOQOL-Bref was obtained on the social domain, followed by the psychological, physical and environmental domains. There was a significant relationship between educational status and the physical, psychological and environmental domains, and the self-perception as a healthy person. There was statistical relationship between individuals' self-perception as a healthy person and both generic questions of the WHOQOL-Bref, as well as the physical, psychological and environmental domains. Regarding the concept of health, subjects' responses were related to their conception of individual's health or to its level of importance to the individual's life. Whit regards to their health needs, the categories mentioned were: Life and work conditions, Psychosocial factors, Individual behaviors, Health care, Spirituality, Quality of life. **Conclusion:** Self-perception as a healthy person was related to the individual's quality of life. Low educational status interferes on the quality of life and on the subject's own self-perception as a healthy person.

Keywords: Quality of life; Speech therapy; Speech, language and hearing sciences; Self assessment; Outpatients; Self-concept; Questionnaires

INTRODUCTION

According to the World Health Organization (WHO), quality of life (QOL) is defined as the "*individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns*"[1].

Since the 1990s, there has been a proliferation of instruments designed to evaluate quality of life, especially in the United States[2]. The lack of such an instrument to evaluate QOL internationally, with a cross-cultural perspective, led the WHO to develop a multicentric project that resulted in the WHOQOL-100, an instrument composed of 100 items for evaluating QOL. The project was developed in 15 centers, in countries with different levels of industrialization and demographic characteristics (Australia, Croatia, France, India, Israel, Japan, the Netherlands, Panama, Russia, Spain, Thailand, the United Kingdom, the United States and Zimbabwe). The 100 questions of the WHOQOL-100 are divided into six domains – psychological, physical, level of independence, social relationships, environment and spirituality – which are, in turn, divided into subgroups[1]. However, the need for a quick application tool led the WHO to develop an abbreviated version of the WHOQOL-100, the WHOQOL-Bref, consisting of 26 questions distributed into four domains: physical, psychological, social relationships and environmental[1].

These tools are based on the notion that QOL is a multidimensional social construct, consisting of positive and negative elements[3].

The Portuguese versions of the WHOQOL-100 and the WHOQOL-Bref[2,4] were applied to 300 individuals each and showed good psychometric performance, suggesting their significance as tools for measuring QOL in Brazil.

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Conflict of interests: None

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When considering the broad concept of QOL, it's admittedly influenced by several factors: employment, housing, access to public services, communication, urbanization, crime, environmental contamination[5].

Just as complex as conceptualizing QOL is the conceptualization of "health", for this too is a broad concept related to the physical, social, political, economic and cultural environment. In developing countries, such as Brazil, the unequal distribution of income, illiteracy, low education level, precarious housing and environmental conditions have an important role in the conditions of life and health. The many factors that determine and influence the health-sickness process are complex and related to economic, sociocultural, personal and lifestyle aspects[6,7].

With the 1947 WHO definition – "*health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity*" – "health" stopped simply representing the absence of disease and became a broad, multidimensional concept, that can be modified according to life perspectives and social roles, and that is related to the state of well-being. Thus, the evaluation of the state of health should be based on the concept of health, inclusively considering its social determinants, such as income, education, housing, labor conditions.

At building their concept and assessing their own health, each individual uses intertwined notions traversed by the perception of QOL, considering physical, emotional and cognitive aspects. Therefore, designing studies which discuss this aggregation of factors in relation to Speech-Language Pathology and Audiology is not only desirable, but necessary to propose health promotion interventions and organize and evaluate related health services.

In the literature, studies have discussed the relationship between Speech-Language Pathology and Audiology and QOL[6,8,9], in addition to studies which presented specific tools for use in speech-language pathology clinical practice, proposing the QOL evaluation in the presence of human communication disorders[10,11].

It is presumed that subjects with positive assessments of their own health, perceiving themselves as healthy beings, would also have positive evaluations of their QOL. With the concepts of health and quality of life being so complex and multidimensional, and recognizing the weight that health has on the quality of life of individuals, the present study had the aims: to evaluate the overall quality of life of adults undergoing speech-language therapy using the WHOQOL-Bref; to investigate these patients' self-perception of health; and to relate the quality of life scores by domain and the general score to socioeconomic and demographic factor and to subjects' self-perception of health.

METHODS

This is an analytical observational, cross-sectional study with non-probability sampling, approved by the Board of Education and Research (protocol Nº 148/06) and by the Ethics Committee of the Universidade Federal de Minas Gerais (UFMG) (protocol ETIC 263/08).

Inclusion criteria for this study were as follows: patients of the Outpatient Clinic of Speech-Language Pathology and Audiology where the study was conducted; patients undergoing speech-language therapy for at least 30 days; adults with at least 18 years old; patients with appropriate neurological and cognitive ability to understand the tool used in the study and to sign the free and informed consent term.

In the first semester of 2007, the Outpatient Clinic of Speech-Language Pathology and Audiology provided care for 169 adult patients. Of these, 53 were excluded from the sample: 32 aphasic individuals, 13 patients which showed signs of dementia/cognitive decline, two with hearing loss and difficulty comprehending the oral and/or graphic coding, six which did not complete 30 days of therapy before the end of the selected semester.

Hence, 116 patients met the inclusion criteria. Of these, three passed away, 14 declined participation due to time unavailability, and two did not feel comfortable answering personal questions. The final research sample consisted of 97 participants who received outpatient voice, orofacial motor, dysphagia, cleft lip and palate, head and neck cancer, or vestibular rehabilitation care. All of the subjects signed the free and informed consent term, agreeing with their participation in the study, as well as with the release of study materials and results as outlined in Resolution 196/96 of the National Health Council.

To fulfill the objectives of this study, two questionnaires were used in the following order:

1. Instrument of Investigation on the Perception of Health (Appendix 1), developed by the researchers, which contains closed questions regarding: socioeconomic data (gender, age, income, level of education, and place of residence); perception of speech-language pathology and audiology problems as health problems; perception of health; and self-assessment of health. Additionally, this tool includes two open questions regarding the individual's conception of health.
2. WHOQOL-Bref, which contains 24 questions that assess physical, psychological, social and environmental domains, and two generic questions. This tool was validated for Brazilian Portuguese[4]. It is worth noting that the scores were obtained using reference and syntax criteria proposed by the WHO[4,8]. Due to the lack of cutoff points for QOL scores, it was decided to use the medians for group comparisons, as suggested by other studies that used the same tool[6,8]. Moreover, the use of medians is justified by the non-gaussian distribution of WHOQOL-Bref scores.

The frequency distribution of all categorical variables was descriptively analyzed, and an analysis of central tendency and dispersion measures for continuous variables was conducted. Analyses to verify associations among demographic variables (socioeconomic, perceptions and self-assessment of health) and the median of WHOQOL-Bref scores were also performed using Chi-square and Fisher's Exact tests. Results with significance level less than or equal to 5% were regarded as significant associations.

For the open questions, we conducted discourse content analysis, a text analysis methodology based on a quantitative

perspective, numerically analyzing the frequency of terms, constructions or references. After selection of the categories to be analyzed in each question, the frequency of occurrence (advent) of terms and expressions in subjects' discourse was obtained[10].

The entry, processing and quantitative analysis of data were carried out using the Software Statistical Package for Social Science (SPSS), version 13 (2007).

RESULTS

In order to facilitate the comprehension of the results, they are presented in three parts.

Part 1. Descriptive analysis of the results of the instruments' questions, and analysis of the WHOQOL-Bref by domain and generic questions

The distribution of the sample regarding gender and age is represented in Figure 1.

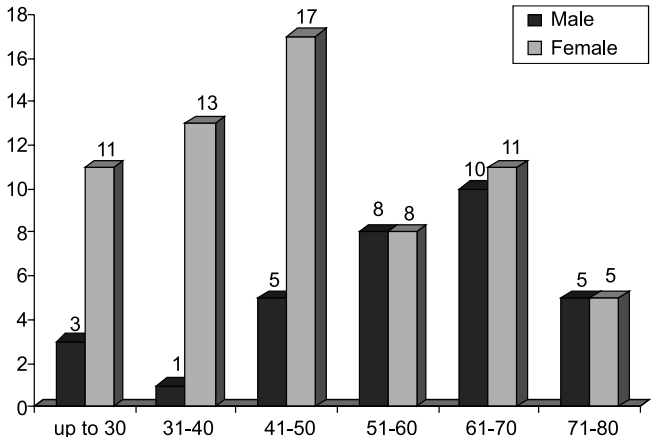

Figure 1. Sample distribution by gender and age (in years)

As for socioeconomic and demographic data, it was found that: 54.6% of the participants were married; 52.6% never attended school or did not complete their primary education; and 70.1% live on an average household income of until three minimum wages.

Phonological disorders were considered health problems by 80.4% of the participants. As for the self-perception of health, 77.3% considered themselves as healthy and 53.6% rated their health as good or very good.

In relation to the QOL assessment using the WHOQOL--Bref, the social domain presented the highest mean score (Table 1).

Part 2. Statistical analysis of associations between research variables

The WHOQOL-Bref scores were compared with the additional research variables (Table 2). Regarding level of education, it was observed a significant relationship between the physical, psychological and environmental domains, that is, the higher the education, the greater the QOL in these domains. Regarding income, there was a significant relationship with the environmental domain, that is, the higher the income, the greater the QOL in this domain. Regarding the perception of health, it was observed that participants who perceived themselves as healthy had better scores in the physical, psychological and environmental domains.

Table 1. Descriptive measures of WHOQOL-Bref scores by domain

Measure	Domain			
	Physical	Psychological	Social	Environmental
Mean	55.49	60.76	69.33	53.79
SD	13.16	13.75	21.30	56.25
Median	57.14	62.50	75.00	15.02

Note: SD = standard deviation

Table 2. Associations (p-values) between WHOQOL-Bref domain scores and education, income and self-perception of health

Variable	Domain			
	Physical	Psychological	Social	Environmental
Education	0.02*	0.05*	0.62	0.01*
Income	0.32	0.11	0.54	0.009*
Self-perception of health	0.02*	0.001*	0.21	0.001*

* Significant values (p<0.05) – Chi-square test

When considering the association between self-assessment of health and the variables gender, age, education and income, it was found a significant relationship with level of education and income, but not with gender and age. Participants with negative self-assessment of their health had lower education level and income (Table 3).

Table 3. Associations (p-values) between self-perception of health and the presence of co-occurrences with gender, age, education and income

	Self-perception of health	Co-occurrences
Gender	0.15	0.07
Age	0.788	0.02*
Education	0.006*	0.001*
Income	0.001*	0.039*

* Significant values (p<0.05) – Chi-square test

Upon analyzing the relationship between co-occurrences with the variables sex, age, education and income, there was a statistically significant association with age, education and income. The presence of co-occurrences was associated with an age greater than 50 years, low education levels and low monthly income.

Part 3. Qualitative analysis of open questions, based on the categorization of participants' answers

Responses to the first open question, "In your opinion, what is health?", were distributed into two categories: "Discourse

focused on the individual's concept of health", which in turn was distributed into "Absence of disease", "Biopsychosocial model of health" and "Quality of life"; and "Discourse focused on the importance of health in an individual's life". The answers that did not fit into any of these specific categories were grouped into "Not possible to categorize" (Chart 1).

Chart 1. Distribution of participants' responses to the question: "In your opinion, what is health?"

Categories	Subcategories	Number of occurrences of the content
Discourse focused on the individuals' concept of health	Absence of disease	19
	Biopsychosocial	30
	Quality of life	28
Discourse focused on the importance of health in an individual's life		10
Not possible to categorize		9
Did not answer		1

The second open question, "In your opinion, what is needed to be healthy?", had responses categorized into: Conditions of life and work; Psychosocial factors; Individual behavior; Health care; Spirituality; Quality of life; Not possible to categorize (Chart 2).

DISCUSSION

Results revealed that most participants considered their speech-language disorders a health problem. Perhaps this stems from the perception that if a difficulty requires treatment, and human communication disorders require speech-language therapy, then that difficulty is a health problem. In addition, some of the speech-language pathology alterations presented by the sample were results of other health events, such as cancer, or stroke, such as in the case of patients with dysphagia, and dysphonia, which cause great social and professional impacts.

Regarding the self-perception of health, more than three fourths of the individuals considered themselves healthy, and more than half rated their health as good or very good. A research[12] with a population sample from an city in Rio Grande do Sul (Brazil) found that 63.2% of the participants self-reported good health.

As for the evaluation of QOL using the WHOQOL-Bref, the highest mean score observed was in the social domain, followed by the psychological, physical and environmental domains. These findings corroborate other studies[13-15] which also evidenced better scores in the social domain and worse scores in the environmental domain. However, the populations in these three studies were distinct: one of the studies focused on the QOL of Mexicans with diabetes mellitus[13]; the other researched community health agents in the state of Paraná (Brazil)[14]; and the last one, public school teachers in a rural municipality of São Paulo[15]. The findings in the present study are slightly different from those found in literature[16-18]. Some authors[16, 17] observed better scores for the social domain, as found in this study, but the worse scores were in the physical and psychological domains, in this order. In other studies the physical domain interfered the most with QOL[18]. Once again it is important to emphasize that are differences between the populations studied: patients with rheumatoid arthritis in In-

Chart 2. Distribution of participants' responses to the question: "In your opinion, what is needed to be healthy?"

Categories	Occurrences	Subcategories content	Number of occurrences of the content
Work and life conditions	9	Income	4
		Employment	4
		Physical environment	1
Psychosocial factors	22	Sense of community belonging	6
		Familial/social support networks	5
		Peace/tranquility	11
Individual behavior	56	Physical activity	26
		Diet	40
		Alcohol/smoking	9
		Lifestyle/behavior	15
		Sleep	15
Healthcare	26	Treatment/monitoring	21
		Not feeling pain/not being sick	5
Spirituality			9
Quality of life			6
Not possible to categorize			6
Did not answer			2

dia[16], elderly individuals in Taiwan[17], and elderly residents in Minas Gerais (Brazil)[18].

The analysis of scores derived from the WHOQOL-Bref in relation to the sociodemographic data showed no significant association with gender[9], age and marital status. Such findings corroborate some of the consulted literature[16, 18], but not the findings of several authors[13,19,20] who studied the QOL of elderly Taiwanese and found that women and widowed/divorced/singles presented lower scores. On the other hand, another author[20], in a study with patients with chronic renal failure, found that married individuals and males had worse QOL assessments. Literature[13] reveals a significant relationship between marital status and the physical domain (those married or cohabiting had higher scores). National studies in Speech-Language Pathology and Audiology[8,9] which studied the QOL of individuals with hearing loss[9] and the elderly[8] found no association between gender and QOL, which coincides with data from this study.

Regarding level of education, a significant relationship was observed in the present study with the physical, psychological and environmental domains; in other words, the higher the education level, the greater the QOL score in these domains. These findings do not support the national literature[18], which did not find significant relationship between these variables. International literature[17] reveals a relationship between level of education and every domain of the WHOQOL-Bref in elderly Taiwanese. Data from the present study corroborate part of the national literature[20], which reported that people with lower education level presented worse scores on the physical and environmental domains, along with the social domain; whereas in this study such a significant association was not found with the social domain.

Concerning income, a significant relationship was found only with the environmental domain, indicating that low monthly income implied a low score on this domain. This finding was not reported in another national study[18], in which income did not interfere with overall QOL. On the other hand, there are findings[13] that show significant relationship between income and the social domain, differently from the present study.

Individuals' self-reported healthy status had a significant association with the physical, psychological and environmental domains; that is, individuals who felt healthy had better QOL scores on these domains. We did not find in literature other studies regarding this association. It is worth noting that both self-perception of health and quality of life are subjective by nature[21].

In the comparison between self-assessment of health and the variables gender, age, level of education and income, it was found that individuals who negatively reported their own health had lower education level and income. This finding corroborate those of other studies[22, 23].

The analysis of the association between presence of co-occurrences and gender, age, level of education and income showed that co-occurrences were related to participants over 50 years old, lower level of education and lower income, corroborating official documents[24] that claim that older and socioeconomically disadvantaged people are more likely to develop diseases. Furthermore, participants with co-occurrences had a negative self-assessment of their own health, while individuals without co-occurrences evaluated their own health as good or very good.

It is noteworthy that the concept of health-sickness process and of social determinants described in theoretical writings and official documents seem to be reproduced in the studied population. Thus, reading and rereading the participants' responses guided the selection of the theoretical framework that supported the selection of categories and subcategories of the questions regarding the health concept and needs. Therefore, in this study, the theoretical framework emerged from the categories and not vice-versa.

Analysis of participant's answers to the question "In your opinion, what is health?" showed two main axes, as shown in Chart 1: "Discourse focused on the individual's concept of health", with 77 answers, and "Discourse focused on the importance of health in an individual's life", with ten answers. Within the first axis, three response categories emerged: Absence of disease; Biopsychosocial model of health; and Quality of life. This classification was chosen based on the evolution of the concepts of health and disease[25]. The findings of the present study corroborate authors[26] who interviewed 42 women in Ribeirão Preto (SP), Brazil. In this study, the authors noticed a strong presence of the biological model of health, since the term was associated to "not feeling anything" and "not having pain". It is noteworthy that, in the present study, some participants conceptualize health by citing diseases/handicaps that they have or have had, also confirming the strong presence of the biological model of health.

In addition to the previous axis, there were ten responses that showed the importance of health in participants' lives, demonstrating their worries regarding health. These answers were similar to those found in another study[27], which researched the meaning of health to mothers in high social risk families, who stated, among other definitions, that health is "the essential to live".

Thus it is not unreasonable to assume that health was viewed by these subjects as a marker of satisfaction, happiness, QOL and social adequacy.

Regarding the second question, "In your opinion, what is needed to be healthy?", it were observed answers referring to social determinants of health, such as work and life conditions, psychosocial factors, and individual behaviors, cited by the Pan American Health Organization[28] (Chart 2). These determinants were considered as categories, along with others that were considered important due to their frequency: Healthcare, Spirituality, and QOL.

Answers regarding the first category were also found in the literature[29], which researched the concept of health among community leaders, and found employment as a synonym of health and inability to work as disease.

In national literature[27], it was observed that mothers of families in social risk based family health on food security, an indicator directly influenced by household income.

In the category "Psychosocial factors", in addition to the subcategories "sense of community belonging" and "familial/social support networks", listed by official documents[28], the subcategory "peace/tranquility" was also included, due to a

significant number of relating answers.

The most cited axis was related to "Individual behaviors". The subcategories observed in the answers were: physical activities, diet, alcohol/smoking, lifestyle/behavior[28], in addition to the subcategory "sleep", which was added to this category due to a large number of responses. Some vignettes may be quoted as representative of this finding: *"It's constantly taking care of your body as to not cause any harm to it." "Not smoking, not drinking, sleeping at least 6 hours, avoiding all types of excess, walking at least 2 km daily." "Good diet, sleeping well and walking a lot."*

A noteworthy finding in the examples cited above was the public concern with the incorporation and maintenance of healthy habits, which highlights the importance of health promotion activities in the population. In a study[30] with community leaders, "diet" was similarly found as a definition of "health".

It was also observed that some participants related health to health care services, such as medical monitoring/treatment, prevention or not feeling pain. An example is found in this vignette: *"Look for doctors, tell them what's happening, what we are suffering from, so that they can give us the medication to overcome."* Thus, an important portion of the sample regarded health services, or healthcare, as a guarantee of health. It is important to stress that guaranteed access to healthcare seems to bring tranquility to the population and secure health.

Spirituality was also cited, which corroborates a literature finding[30] that obtained answers affirming faith and divine intervention as necessary for health.

"Quality of life" was also cited as a factor needed for health. It is unknown, however, whether participants' knowledge regarding the purposes of the study influenced the use of this terminology, since the aims were presented in the consent form.

Most participants included various axes in their answers, attributing health to several health determinants, as supported by other studies[6,7], which reported that health is determined and conditioned by many social, economic, cultural, physical and lifestyle factors. In a national study[8] 35% of 160 interviewees related health to social, economic, biological and psychological aspects, a percentage similar to this study.

There is growing scientific production by speech-language pathologists on the theme of subjective evaluations of health and quality of life[6,8-11,15]. Besides the authors that used the same instrument of the present study (WHOQOL-Bref), it is also worth noting the efforts to produce instruments specific to the field of Speech-Language Pathology and Audiology[10,11,15]. Although these studies have highlighted the relationship between QOL and human communication, the combination of self-perception of health and Speech-Language Pathology and Audiology is still incipient, showing a need for deepening the understanding of these relationships.

As in the present study, literature[29] points to the impossibility of establishing a universal indicator of health, because an indicator assumed to be universal, or applicable to all people of all cultures, cannot be refuted by a single social group or individual as the meaning of health. Likewise, a common health indicator for a society may not be part of the understanding of health by an individual in that society.

Regarding the open questions, it's worth noting that although they have contributed to the understanding of the participant's concept of health, they do not allow the discussion of all the complexities and nuances of the concept of health. Thus, studies with qualitative content analysis methods or discourse analysis are needed for further understanding of the theme.

The present study used a sample of patients of only one Outpatient Clinic of Speech-Language Pathology and Audiology; however, it showed that the association between self-perception of health and quality of life in individuals with communication disorders is worth exploring. It is emphasized that the planning of clinical care strategies and collective health care promotion and intervention related to speech-language disorders must consider elements that refer to population demands and concepts of health and disease. In order to achieve this, it is necessary to further discuss the theme and validate the use of appropriate instruments and protocols. The triangulation of national and international findings with quantitative and qualitative data should be sought as a means of widening the discussion and advancing science.

CONCLUSION

The WHOQOL-Bref was found to be a useful instrument in clinical practice, allowing for a greater understanding of patients and their needs. To the extent that it allows for the identification of the areas in which the quality of life of the patient is mostly affected, it provides the clinician the understanding of possible interferences of these domains over therapeutic success.

After analyzing the relationship between overall quality of life and self-perception of health, it was observed that individuals who perceived themselves as healthy also presented better assessments of their quality of life. Furthermore, it was found that subjects' self-perception of health and QOL was influenced by level of education, that is, the greater the education level, the better the perception of health and QOL.

The analysis of open questions showed that, for the majority of the study population, health is understood as multidimensional, and that health necessities and problems outweigh biological issues, including psychosocial, spiritual and socioeconomic factors, such as the incorporation of healthy habits, quality of life and work. Another relevant finding was the perception that ensuring access to health services, i.e. healthcare, is considered by the participants as an important factor for ensuring health.

RESUMO

Objetivos: Avaliar a qualidade de vida global dos indivíduos adultos em atendimento fonoaudiológico, por meio do WHOQOL-Abreviado; investigar a autopercepção e o conceito de saúde desses indivíduos. **Métodos:** Dois questionários foram aplicados a 97 pacientes adultos em atendimento em Ambulatório de Fonoaudiologia: o Instrumento de Investigação sobre a Percepção de Saúde, composto por questões fechadas e abertas, e o WHOQOL-Abreviado. Foi utilizada análise de conteúdo para analisar as questões abertas, e os escores foram analisados estatisticamente. **Resultados:** O domínio do WHOQOL-Abreviado que apresentou maior escore foi o social, seguido pelo psicológico, o físico e o meio ambiente. Houve relação significativa entre a escolaridade e os domínios físico, psicológico e meio ambiente e entre a autopercepção como pessoa saudável. A percepção do indivíduo como pessoa saudável apresentou relação estatística com as duas questões genéricas do WHOQOL-Abreviado e com os domínios físico, psicológico e meio ambiente. Quanto ao conceito de saúde, os sujeitos referiram respostas relacionadas à concepção de saúde do indivíduo ou ao grau de importância na vida do indivíduo. Quanto às necessidades em saúde, as categorias elencadas foram: Condições de vida e trabalho, Fatores psicossociais, Comportamentos individuais, Assistência à saúde, Espiritualidade, Qualidade de vida. **Conclusão:** A autopercepção como ser saudável apresentou relação com a qualidade de vida do sujeito. A baixa escolaridade interferiu na qualidade de vida e na própria percepção do sujeito como pessoa saudável.

Descritores: Qualidade de vida; Fonoterapia; Fonoaudiologia; Auto-avaliação; Pacientes ambulatoriais; Auto-imagem; Questionários

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Appendix 1. Instrument of Investigation on the Perception of Health

1. Gender: ( ) M ( ) F
2. Age:____
3. Education level:
( ) Incomplete Elementary education
( ) Complete Elementary education
( ) Incomplete High School
( ) Complete High School
( ) Incomplete undergraduate study
( ) Complete undergraduate study
( ) Technical training
( ) Never attended formal schooling

4. Marital status:
( ) Single
( ) Married
( ) Cohabiting as married
( ) Separated
( ) Divorced
( ) Widowed

5. Average household income:
( ) Up to 1 minimum wage
( ) Between 1 and 3 minimum wages
( ) Between 4 and 5 minimum wages
( ) Between 6 and 7 minimum wages
( ) Between 8 and 10 minimum wages
( ) More than 10 minimum wages

6. Place of residence:
( ) Baldim
( ) Belo Horizonte
( ) Betim
( ) Brumadinho
( ) Caeté
( ) Capim Branco
( ) Confins
( ) Contagem
( ) Esmeraldas
( ) Florestal
( ) Ibirité
( ) Igarapé
( ) Itaguara
( ) Itatiaiuçu
( ) Jaboticatubas
( ) Juatuba
( ) Lagoa Santa
( ) Mário Campos
( ) Mateus Leme
( ) Matozinhos
( ) Nova Lima
( ) Nova União
( ) Pedro Leopoldo
( ) Raposos
( ) Ribeirão das Neves
( ) Rio Acima
( ) Rio Manso
( ) Sabará
( ) Santa Luzia
( ) São Joaquim de Bicas
( ) São José da Lapa
( ) Sarzedo
( ) Taquaraçu de Minas
( ) Vespasiano
( ) Other city in Minas Gerais

7. Does the speech-language disorder interfere with your daily activities?
( ) Completely ( ) Very
( ) Moderately ( ) Slightly ( ) Not at all

8. Is the reason you sought care at the Outpatient Clinic of Speech-Language Pathology and Audiology a health problem?
( ) Yes ( ) No

9. Are you currently experiencing any of the following conditions?
( ) Cancer
( ) Diabetes
( ) High cholesterol
( ) Thyroid gland problems
( ) Hormonal problems
( ) Depression (only if taking depression medication)
( ) Alcohol or drug problem (in medical treatment)
( ) Migraines
( ) Multiple Sclerosis
( ) Epilepsy
( ) Cataracts
( ) Glaucoma
( ) Deafness/hearing loss
( ) Cardiac problem
( ) High blood pressure
( ) Thrombosis
( ) Stroke
( ) Asthma/bronchitis/sinusitis/rhinitis
( ) Emphysema
( ) Gastritis, esophagitis, ulcers
( ) Kidney problems
( ) Skin problems

( ) Arthritis or rheumatism
( ) Back pain
( ) None of these
( ) Others (please specify)

10. Do you consider yourself a healthy person?
( ) Yes ( ) No

11. How is your health?
( ) Very bad
( ) Bad
( ) Neutral
( ) Good
( ) Very good

12. In your opinion, what is health?

13. In your opinion, what is needed to be healthy?

For interviewer use:
Outpatient care:
( ) Voice
( ) Orofacial motor
( ) Cleft lip and palate
( ) Hearing loss
( ) Dysfluency
( ) Aphasia
( ) Aging
( ) Dysphagia
( ) Head or neck cancer
( ) Vestibular rehabilitation

Form of administration:
( ) Self-administered
( ) Assisted by the interviewer
( ) Administered by the interviewer