

# ANNEX C: HEALTH AND WELLBEING SURVEY

This annex contains the questionnaire that was used for the Health and Wellbeing Survey.



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## Health and Wellbeing Survey

### Instructions to complete:

This questionnaire asks about your physical and mental health. All information you provide in this questionnaire will be de-identified and will not be linked to other data we have collected about your health without your consent.

Please complete all sections by following the instructions at the beginning of each question. Please shade circles, rather than ticking or crossing them, and write clearly and in capital letters.

Shade Circles Like This--> ●

Not Like This--> ⊗ ⊕

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

If you make a mistake and wish to change your answer, simply cross out your mistake and choose the answer that is right for you.

Please use blue or black pen, not pencil.

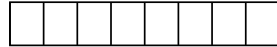
Some questions may seem repetitive, but this is necessary due to the questions being grouped into scales.

If you have any questions, please call us on 1800 232 904.





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### **SUPPORT**

If you find involvement in the survey distressing in any way you can talk to someone about it.

+ **All Hours Support Line** 1800 628 036; Outside Australia +61 2 9425 3878  
A confidential telephone triage support service for ADF members and their families

+ **Lifeline** 13 11 14

+ **Veterans and Veterans' Family Counselling Service** 1800 011 046

+ **Veterans' Affairs Network (VAN)** 1300 551 918; Non-metro 1800 555 254

+ **Department of Veterans' Affairs** 13 32 54

+ **National Office for the Military Compensation and Rehabilitation Service** 1300 550 461

If you prefer to speak to an independent University or Defence Force representative not involved in the study, contact an Ethics Officer:

+ **The Australian Defence Force Human Research Ethics Committee**  
Executive Secretary  
(02) 6266 3837; ADHREC@defence.gov.au

+ **The University of Adelaide Research Branch**  
Secretary, Human Research Ethics Committee  
(08) 8303 6028

IF YOU DO NOT WANT TO PARTICIPATE IN THIS STUDY - PLEASE PHONE THE TOLL FREE NUMBER  
1800 232 904

For questions, problems or concerns, please contact the following:

+ **The Study Team**  
The Centre for Military and Veterans' Health  
1800 232 904; cmvh@adelaide.edu.au

+ **Principal Investigator: Prof Alexander McFarlane**  
University of Adelaide  
(08) 8303 5200; alexander.mcfarlane@adelaide.edu.au



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**Section One: Background Details**

1.1 What is today's date? (dd/mm/yyyy)  /  / 2 0 1 1

1.2 Are you male or female?  Male  Female

1.3 What is your date of birth? (dd/mm/yyyy)  /  /

1.4 Are you currently in a significant intimate relationship?  Yes - go to question 1.4a  No - go to question 1.4b

<p>1.4a Are you:</p> <ul style="list-style-type: none"> <li><input type="radio"/> Married and living together</li> <li><input type="radio"/> Married with unaccompanied spouse (i.e. married partner currently lives elsewhere)</li> <li><input type="radio"/> Living with partner (ADF recognised)</li> <li><input type="radio"/> Living with partner (not ADF recognised)</li> <li><input type="radio"/> In a long term relationship but not living together</li> </ul>	<p>1.4b Are you:</p> <ul style="list-style-type: none"> <li><input type="radio"/> Never married</li> <li><input type="radio"/> Previously married but now divorced</li> <li><input type="radio"/> Previously married but now separated</li> <li><input type="radio"/> Other, please specify: <input type="text"/></li> </ul>
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1.5 Which category best describes the highest educational qualification you have completed? Choose one.

- Primary school
- Secondary school up to grade 10
- Secondary school grades 11-12
- Certificate (trade, apprenticeship, technicians etc)
- Diploma (associate, undergraduate)
- Bachelor degree
- Post-graduate qualification

1.6 What is your Service?  Royal Australian Navy  Australian Regular Army  Royal Australian Air Force

1.7 To the nearest year, how long have you served with the Australian Defence Force: (if less than 1 year, please enter 1)

a) As a regular?  years or  Not applicable

b) As a reservist?  years or  Not applicable



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### Section One: Background Details

1.8 What is your CURRENT rank?

Senior Commissioned Officer (CMDR / LTCOL / WGCDR and above)  
 Commissioned Officer (LCDR / MAJ / SQNLDR and below)  
 Senior Non-Commissioned Officer (PO / SGT and above)  
 Junior Non-Commissioned Officer (LS / CPL and below)  
 Other ranks (AB / SMN / PTE / LAC / AC or equivalent)

1.9 In the past THREE YEARS, roughly how many months in total have you been away on operational deployment? (if less than 1 month, please enter 1)   months

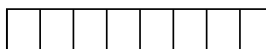
1.10 If in the Navy, in the past THREE YEARS, roughly how many months in total have you been deployed on a ship? (if less than 1 month, please enter 1)   months or  Not applicable

1.11 Are you currently on operational deployment?  No  Yes

1.12 How long do you intend to stay in the military?   years   months



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## Section Two: Your Health Now

2.1 In general, how would you say your health is?     Excellent     Very good     Good     Fair     Poor

In general, how would you rate your:

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
2.2 Quality of life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.3 Eyesight (with glasses or contact lenses, if you wear them)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.4 Hearing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.5 Memory?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.6 Teeth and gums?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The following questions inquire about how you have been feeling over the last four (4) weeks. Please read each question carefully and then indicate, by shading the circle, the response that best describes how you have been feeling.

	ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
2.7 In the past four (4) weeks, about how often did you feel tired for no good reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.8 In the past four (4) weeks, about how often did you feel nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.9 In the past four (4) weeks, about how often did you feel so nervous that nothing could calm you down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.10 In the past four (4) weeks, about how often did you feel hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.11 In the past four (4) weeks, about how often did you feel restless or fidgety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.12 In the past four (4) weeks, about how often did you feel so restless that you could not sit still?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.13 In the past four (4) weeks, about how often did you feel depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.14 In the past four (4) weeks, about how often did you feel that everything was an effort?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.15 In the past four (4) weeks, about how often did you feel so sad that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.16 In the past four (4) weeks, about how often did you feel worthless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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## Section Two: Your Health Now

The next few questions are about how these feelings may have affected you in the past four (4) weeks. You need not answer these questions if you answered 'None of the time' to all of the previous ten questions about your feelings.

2.17 In the past four (4) weeks, how many days were you **TOTALLY UNABLE** to work, study or manage your day to day activities because of these feelings?   days

2.18 [Aside from those days], in the past four (4) weeks, **HOW MANY DAYS** were you able to work or study or manage your day to day activities, but had to **CUT DOWN** on what you did because of these feelings?   days

2.19 In the past four (4) weeks, how many times have you seen a doctor or any other health professional about these feelings?   times

2.20 In the past four (4) weeks, how often have physical health problems been the main cause of these feelings?  
 None of the time    A little of the time    Some of the time    Most of the time    All of the time

2.21 Please rate the following statements based on how you have felt in the past 30 days using the scale below.

	NOT TRUE AT ALL	RARELY TRUE	SOME-TIMES TRUE	OFTEN TRUE	TRUE NEARLY ALL THE TIME
a) I am able to adapt to change	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) I tend to bounce back after illness or hardship	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

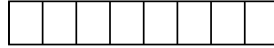
2.22 How satisfied are you with your marriage / relationship?

Extremely satisfied  
 Satisfied  
 Neither satisfied or dissatisfied  
 Dissatisfied  
 Extremely dissatisfied  
 Not applicable

2.23 Overall, what impact have your military commitments had on your:

a) <u>Marriage / relationship?</u> <input type="radio"/> No impact <input type="radio"/> Positive impact <input type="radio"/> Negative impact <input type="radio"/> Not applicable	b) <u>Children?</u> <input type="radio"/> No impact <input type="radio"/> Positive impact <input type="radio"/> Negative impact <input type="radio"/> Not applicable
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**Section Three: Lifestyle Behaviours**

3.9. How often do you have a drink containing alcohol? Never Monthly or Less 2 to 4 times a month 2 to 3 times a week 4 or more times a week

In answering the following questions, please remember that a standard drink contains 10g of pure alcohol

### Standard Drinks Guide

									
<b>1.5</b>	<b>1</b>	<b>0.8</b>	<b>1.5</b>	<b>1</b>	<b>0.8</b>	<b>1</b>	<b>0.7</b>	<b>0.5</b>	<b>1.5</b>
375ml Full Strength Beer 4.9% Alc./Vol	375ml Mid Strength Beer 3.5% Alc./Vol	375ml Light Beer 2.7% Alc./Vol	375ml Full Strength Beer 4.9% Alc./Vol	375ml Mid Strength Beer 3.5% Alc./Vol	375ml Light Beer 2.7% Alc./Vol	285ml Middy/Pot* Full Strength Beer 4.9% Alc./Vol	285ml Middy/Pot* Mid Strength Beer 3.5% Alc./Vol	285ml Middy/Pot* Light Beer 2.7% Alc./Vol	170ml Standard Serve of Sparkling Wine/Champagne 11.5% Alc./Vol
									
<b>1.5</b>	<b>1.5</b>	<b>1</b>	<b>22</b>	<b>0.9</b>	<b>1</b>	<b>1.8</b>	<b>7</b>	<b>38</b>	
375ml Pre-mix Spirits 5% Alc/Vol	340ml Alcoholic Soda 5.5% Alc/Vol	30ml Spirit Nip 40% Alc/Vol	700ml Bottle of Spirits 40% Alc/Vol	60ml Port/Sherry Glass 18% Alc/Vol	100ml Standard Serve of Wine 12% Alc/Vol	180ml Average Restaurant Serve of Wine 12% Alc/Vol	750ml Bottle of Wine 12% Alc/Vol	4 Litres Cask Wine 12% Alc/Vol	

\* NSW, WA, ACT = Middy; VIC, QLD, TAS = Pot; NT = Handie; SA = Schooner

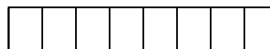
3.10 How many 'standard' drinks (see above) containing alcohol do you have on a typical day when you are drinking? 1 or 2 3 or 4 5 or 6 7 to 9 10 or more N/A

	NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
3.11 How often do you have six or more drinks on one occasion?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.12 How often during the last 12 months have you found that you were not able to stop drinking once you had started?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.13 How often during the last 12 months have you failed to do what was normally expected from you because of drinking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





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### Section Three: Lifestyle Behaviours

	NEVER	LESS THAN ONCE A MONTH	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY	
3.14 How often during the last 12 months have you needed a drink in the morning to get yourself going after a heavy drinking session?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
3.15 How often during the last 12 months have you had a feeling of guilt or remorse after drinking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
3.16 How often during the last 12 months have you been unable to remember what happened the night before because you had been drinking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
3.17 Have you or someone else been injured as a result of your drinking?	No <input type="radio"/>	Yes, but not in the last 12 months <input type="radio"/>		Yes, during the last 12 months <input type="radio"/>		
3.18 Has a relative, a friend, a doctor or other health professional been concerned about your drinking or suggested you cut down?	No <input type="radio"/>	Yes, but not in the last 12 months <input type="radio"/>		Yes, during the last 12 months <input type="radio"/>		
3.19 Do you presently have a problem with drinking?	No <input type="radio"/>	Probably not <input type="radio"/>	Unsure <input type="radio"/>	Possibly <input type="radio"/>	Definitely <input type="radio"/>	
3.20 In the next 3 months, how difficult would you find it to cut down or stop drinking?	Very easy <input type="radio"/>	Fairly easy <input type="radio"/>	Neither difficult nor easy <input type="radio"/>	Fairly difficult <input type="radio"/>	Very difficult <input type="radio"/>	N/A <input type="radio"/>

3.21 On an average day, how many 250 - 375ml beverages containing caffeine do you drink (such as caffeine containing energy drinks, coffee, tea, coca-cola)?

None     1-2 per day     3-5 per day     6-10 per day     11 or more per day

3.22 How often do you currently take any of the following supplements?

	NEVER	LESS THAN ONCE A MONTH	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
a) Body building supplements (such as amino acids, weight gain products, creatine, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) Energy supplements (such as energy drinks, pills, or energy enhancing herbs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) Weight loss supplements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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### Section Four: Past Experiences

Please indicate if you have ever in your lifetime experienced any of the following events:

	EXPERIENCED EVENT	NO. OF TIMES	AGE FIRST TIME	AGE LAST TIME
4.1 Direct combat	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.2 Life-threatening accident	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.3 Fire, flood, or other natural disaster	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.4 Witness someone badly injured or killed	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.5 Rape	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.6 Sexual molestation	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.7 Serious physical attack or assault	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.8 Threatened / harassed without weapon	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.9 Threatened with weapon / held captive / kidnapped	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.10 Tortured or victim of terrorists	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.11 Domestic violence	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.12 Witnessed domestic violence	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.13 Finding dead body	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.14 Witnessed someone suicide or attempt suicide	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.15 Child abuse - physical	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.16 Child abuse - emotional	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.17 Any other stressful event, please specify:	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
		<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
4.18 Did you ever suffer a great shock because one of these events happened to someone close to you? Please specify event type:	○ No ○ Yes	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>
		<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>	<input style="width: 25px; height: 20px;" type="text"/>



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## Section Four: Past Experiences

4.19 Please shade the circle indicating your worst event.

- Direct combat
- Life-threatening accident
- Fire, flood, or other natural disaster
- Witness someone badly injured or killed
- Rape
- Sexual molestation
- Serious physical attack or assault
- Threatened / harassed without weapon
- Threatened with weapon / held captive / kidnapped
- Tortured or victim of terrorists
- Domestic violence
- Witness domestic violence
- Finding dead body
- Witness someone suicide or attempt suicide
- Child abuse - physical
- Child abuse - emotional
- Any other stressful event
- Event that happened to someone close to you





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### Section Four: Past Experiences

Thinking about your response to the previous question (question 4.19):

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then shade the circle to the right to indicate how much you have been bothered by that problem in the past month.

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
4.20 Repeated, disturbing <u>memories, thoughts or images</u> of a stressful experience from the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.21 Repeated, disturbing <u>dreams</u> of a stressful experience from the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.22 Suddenly <u>acting or feeling</u> as if a stressful experience from the past were happening again (as if you were reliving it)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.23 Feeling <u>very upset</u> when <u>something reminded you</u> of a stressful experience from the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.24 Having <u>physical reactions</u> (e.g. heart pounding, trouble breathing, sweating) when <u>something reminded you</u> of a stressful experience from the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.25 Avoiding <u>thinking about or talking about</u> a stressful experience from the past or avoiding <u>having feelings</u> related to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.26 Avoiding <u>activities or situations</u> because <u>they reminded you</u> of a stressful experience from the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.27 Trouble <u>remembering important parts</u> of a stressful experience from the past?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.28 <u>Loss of interest</u> in activities that you used to enjoy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.29 Feeling <u>distant or cut off</u> from other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.30 Feeling <u>emotionally numb</u> or being unable to have loving feelings for those close to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.31 Feeling as if your <u>future</u> somehow will be <u>cut short</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.32 Trouble <u>falling or staying</u> asleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.33 Feeling <u>irritable</u> or having <u>angry outbursts</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.34 Having <u>difficulty concentrating</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.35 Being <u>"superalert"</u> or watchful or on guard?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.36 Feeling <u>jumpy</u> or easily startled?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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### Section Four: Past Experiences

4.37 Thinking over the past 4 weeks, shade the circle that best describes the amount of time you felt that way.

	NONE OF THE TIME	A LITTLE OF THE TIME	SOME OF THE TIME	MOST OF THE TIME	ALL OF THE TIME
a) I found myself getting angry at people or situations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) When I got angry, I got really mad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) When I got angry, I stayed angry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d) When I got angry at someone, I wanted to hit them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e) My anger interfered with my ability to get my work, study or other productive activity done	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f) My anger prevented me from getting along with people as well as I'd have liked to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g) I became angry at myself when I did not perform as well or achieve what I wanted	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h) I became angry at myself when I did not handle social situations as well as I wanted	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i) My anger had a bad effect on my health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4.38 How often over the last month did you get into a fight with someone and hit the person?  
 Never     One time     Two times     Three or four times     Five or more times

4.39 How often over the last month did you threaten someone with physical violence?  
 Never     One time     Two times     Three or four times     Five or more times





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## Section Four: Past Experiences

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
4.40 Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.41 Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.42 Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.43 Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.44 Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.45 Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.46 Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.47 Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.48 Thoughts that you would be better off dead or of hurting yourself in some way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.49 If you checked off any of these problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				
<input type="radio"/> Not difficult at all <input type="radio"/> Somewhat difficult <input type="radio"/> Very difficult <input type="radio"/> Extremely difficult				

The next group of questions are about anxiety.

	NO	YES
4.50 In the <u>last 4 weeks</u> , have you had an anxiety attack - suddenly feeling fear or panic?	<input type="radio"/>	<input type="radio"/>
<b>If NO: please skip to question 4.65</b>		
4.51 Has this ever happened before?	<input type="radio"/>	<input type="radio"/>
4.52 Do some of these attacks come <u>suddenly out of the blue</u> - that is, in situations where you don't expect to be nervous or uncomfortable?	<input type="radio"/>	<input type="radio"/>
4.53 Do these attacks bother you a lot or are you worried about having another attack?	<input type="radio"/>	<input type="radio"/>



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### Section Four: Past Experiences

Think about your last bad anxiety attack.

	NO	YES
4.54 Were you short of breath?	<input type="radio"/>	<input type="radio"/>
4.55 Did your heart race, pound, or skip?	<input type="radio"/>	<input type="radio"/>
4.56 Did you have chest pain or pressure?	<input type="radio"/>	<input type="radio"/>
4.57 Did you sweat?	<input type="radio"/>	<input type="radio"/>
4.58 Did you feel as if you were choking?	<input type="radio"/>	<input type="radio"/>
4.59 Did you have hot flushes or chills?	<input type="radio"/>	<input type="radio"/>
4.60 Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhoea?	<input type="radio"/>	<input type="radio"/>
4.61 Did you feel dizzy, unsteady, or faint?	<input type="radio"/>	<input type="radio"/>
4.62 Did you have tingling or numbness in parts of your body?	<input type="radio"/>	<input type="radio"/>
4.63 Did you tremble or shake?	<input type="radio"/>	<input type="radio"/>
4.64 Were you afraid you were dying?	<input type="radio"/>	<input type="radio"/>

Over the last 4 weeks, how often have you been bothered by any of the following problems?

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS
4.65 Feeling nervous, anxious, on edge, or worrying a lot about different things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>If NOT AT ALL: please skip to question 4.72</b>			
4.66 Feeling restless so that it is hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.67 Getting tired very easily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.68 Muscle tension, aches, or soreness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.69 Trouble falling asleep or staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.70 Trouble concentrating on things, such as reading a book or watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.71 Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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### Section Four: Past Experiences

Please shade the circles that best describe your experience.

- |  |                          |                           |
|--|--------------------------|---------------------------|
| 4.72 In the last 12 months, have you ever felt that life was not worth living?                   | <input type="radio"/> No | <input type="radio"/> Yes |
| 4.73 In the last 12 months, have you ever felt so low that you thought about committing suicide? | <input type="radio"/> No | <input type="radio"/> Yes |
| 4.74 In the last 12 months, have you made a suicide plan?  | <input type="radio"/> No | <input type="radio"/> Yes |
| 4.75 In the last 12 months, have you attempted suicide?  | <input type="radio"/> No | <input type="radio"/> Yes |

**If you require support in relation to any issues you have identified in this survey, we encourage you to refer to the contacts provided on the inside cover.**

4.76 Please rate your current (i.e. last 2 weeks) sleeping pattern:

	NONE	MILD	MODERATE	SEVERE	VERY
Difficulty falling asleep:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty staying asleep:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem waking up too early:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4.77 How satisfied / dissatisfied are you with your current sleep pattern?

- Very satisfied     
  Satisfied     
  Neutral     
  Dissatisfied     
  Very dissatisfied





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## Section Five: Getting Help

5.1 Have you sought help for a stress, emotional, mental health or family problem in the last 12 months?  No  Yes

Here is a list of concerns that a person might have when they consider seeking help for these problems. Please indicate how each of these concerns might affect YOUR decision to seek help.

	STRONGLY DISAGREE	DISAGREE	UNCERTAIN	AGREE	STRONGLY AGREE
5.2 I wouldn't know where to get help	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.3 I would have difficulty getting time off work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.4 It would harm my career or career prospects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.5 People would treat me differently	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.6 I would be seen as weak	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.7 It would stop me from being deployed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**You are over half way through the questionnaire. Keep going!**





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## Section Six: Social Support

The next group of questions are about your relationships with other people.

	OFTEN	SOMETIMES	RARELY	NEVER
6.1 How often do <u>friends</u> make you feel cared for?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.2 How often do they express interest in how you are doing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.3 How often do friends make too many demands on you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.4 How often do they criticise you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.5 How often do friends create tensions or arguments with you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	OFTEN	SOMETIMES	RARELY	NEVER
6.6 How often do <u>family</u> make you feel cared for?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.7 How often do family express interest in how you are doing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.8 How often do they make too many demands on you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.9 How often do family criticise you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.10 How often do they create tensions or arguments with you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The next group of questions are about your relationship with the members of your workplace.

	OFTEN	SOMETIMES	RARELY	NEVER
6.11 How often do <u>members of your workplace</u> make you feel supported?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.12 How often do they express interest in how you are doing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.13 How often do they make too many demands on you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.14 How often do they criticise you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.15 How often do they create tensions or arguments with you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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**Section Six: Social Support**

	OFTEN	SOMETIMES	RARELY	NEVER
6.16 How often does <u>your direct supervisor (i.e. the person who writes your performance report)</u> make you feel supported?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.17 How often does he / she express interest in how you are doing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.18 How often does he / she make too many demands on you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.19 How often does he / she criticise you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.20 How often does he / she create tensions or arguments with you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6.21 In the last month, the level of morale in my immediate workplace / work team was high.

Strongly disagree   
  Disagree   
  Neither agree nor disagree   
  Agree   
  Strongly agree



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## Section Seven: Recent Health Symptoms

7.1 During the past 4 weeks, how much have you been bothered by any of the following problems?

	NOT BOTHERED AT ALL	BOTHERED A LITTLE	BOTHERED A LOT
a) Stomach pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) Back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) Pain in your arms, legs, or joints (knees, hips, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d) Menstrual cramps or other problems with your periods [ <i>Women only</i> ]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e) Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f) Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g) Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h) Fainting spells	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i) Feeling your heart pound or race	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j) Shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k) Pain or problems during sexual intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l) Constipation, loose bowels, or diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m) Nausea, gas, or indigestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n) Feeling tired or having low energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o) Trouble sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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**Section Seven: Recent Health Symptoms**

7.2 During your lifetime, did you experience any of the following events?		
Blast or Explosion IED (improvised explosive device)	<input type="radio"/> No	<input type="radio"/> Yes
RPG (rocket propelled grenade), Land Mine, Grenade, etc.	<input type="radio"/> No	<input type="radio"/> Yes
Vehicular accident / crash (any vehicle, including aircraft)	<input type="radio"/> No	<input type="radio"/> Yes
Fragment wound or bullet wound above the shoulders	<input type="radio"/> No	<input type="radio"/> Yes
Fall	<input type="radio"/> No	<input type="radio"/> Yes

**If NO to all events in 7.2: please skip to question 8.1. Otherwise, continue.**

7.3 How many times in total have you experienced each of the following symptoms immediately after any of the events listed above?		
Loss of consciousness / "knocked out"	<input type="text"/> <input type="text"/>	times
Being dazed, confused, or "seeing stars"	<input type="text"/> <input type="text"/>	times
Not remembering the event	<input type="text"/> <input type="text"/>	times
Concussion	<input type="text"/> <input type="text"/>	times
Head injury	<input type="text"/> <input type="text"/>	times

7.4 Did any of the following problems begin or get worse after any of the events listed above?					
Memory problems or lapses	<input type="radio"/> No	<input type="radio"/> Yes	Irritability	<input type="radio"/> No	<input type="radio"/> Yes
Balance problems or dizziness	<input type="radio"/> No	<input type="radio"/> Yes	Headaches	<input type="radio"/> No	<input type="radio"/> Yes
Sensitivity to bright light	<input type="radio"/> No	<input type="radio"/> Yes	Sleep problems	<input type="radio"/> No	<input type="radio"/> Yes

7.5 In the past week, have you had any of these symptoms?					
Memory problems or lapses	<input type="radio"/> No	<input type="radio"/> Yes	Irritability	<input type="radio"/> No	<input type="radio"/> Yes
Balance problems or dizziness	<input type="radio"/> No	<input type="radio"/> Yes	Headaches	<input type="radio"/> No	<input type="radio"/> Yes
Sensitivity to bright light	<input type="radio"/> No	<input type="radio"/> Yes	Sleep problems	<input type="radio"/> No	<input type="radio"/> Yes



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**Section Eight: Occupational Issues**

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	STRONGLY AGREE	N/A
8.1 I am adequately recognised and rewarded for my work by:						
My current remuneration package (i.e. salary, allowances, medical superannuation)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Verbal recognition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Awards / Honours / Medals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.2 I have experienced bullying in my job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
8.3 I believe Defence appropriately handles bullying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	



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### Section Nine: Evaluation Questions

9.1 Do you have any additional comments you would like to add?

Yes  No

If **YES**: please give details in the space provided





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**Section Ten: Brief Deployment History**

10.1 Have you been on an ADF operational deployment? (war-like, peacekeeping, peace-monitoring or humanitarian support)  
 Yes - **please continue**       No - **please skip to question 10.3**

**Instructions:** Please indicate which of the following major operations you have been deployed on (*please complete as much of this information as you can*).

COUNTRY	OPERATION NAME	YEAR(S) DEPLOYMENT(S) STARTED	NO. OF TIMES DEPLOYED IN YEAR	TOTAL TIME DEPLOYED (MONTHS)
<input type="radio"/> Afghanistan or areas supporting operations in Afghanistan	<input type="radio"/> OP SLIPPER	<input type="radio"/> 2001	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2002	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2003	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2004	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2005	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2006	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2007	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2008	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2009	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2010	<input type="text"/>	<input type="text"/>





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**Section Ten: Brief Deployment History**

COUNTRY	OPERATION NAME	YEAR(S) DEPLOYMENT(S) STARTED	NO. OF TIMES DEPLOYED IN YEAR	TOTAL TIME DEPLOYED (MONTHS)					
<input type="radio"/> Iraq or areas supporting operations in Iraq	<input type="radio"/> OP BASTILLE	<input type="radio"/> 2002	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>			
	<input type="radio"/> 2003	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>				
	<input type="radio"/> OP FALCONER	<input type="radio"/> OP CATALYST	<input type="radio"/> 2003	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>		
			<input type="radio"/> 2004	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>		
<input type="radio"/> 2005			<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>			
<input type="radio"/> 2006	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>					
<input type="radio"/> 2007	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>					
<input type="radio"/> 2008	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>					
<input type="radio"/> 2009	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>					
<input type="radio"/> OP KRUGER	<input type="radio"/> 2009	<input type="radio"/> 2009	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>			
<input type="radio"/> 2010	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>					
<input type="radio"/> Solomon Islands	<input type="radio"/> OP ANODE	<input type="radio"/> 2003	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>			
		<input type="radio"/> 2004	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>			
		<input type="radio"/> 2005	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>			
<input type="radio"/> 2006	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>					
<input type="radio"/> 2007	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>					
<input type="radio"/> 2008	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>					
<input type="radio"/> 2009	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>					
<input type="radio"/> 2010	<table border="1"> <tr><td></td><td></td></tr> </table>			<table border="1"> <tr><td></td><td></td></tr> </table>					



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**Section Ten: Brief Deployment History**

COUNTRY	OPERATION NAME	YEAR(S) DEPLOYMENT(S) STARTED	NO. OF TIMES DEPLOYED IN YEAR	TOTAL TIME DEPLOYED (MONTHS)
<input type="radio"/> East Timor	<input type="radio"/> InterFET, OP FABER, OP SPITFIRE, OP WARDEN	<input type="radio"/> 1999	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2000	<input type="text"/>	<input type="text"/>
	<input type="radio"/> OP TANAGER	<input type="radio"/> 2000	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2001	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2002	<input type="text"/>	<input type="text"/>
	<input type="radio"/> OP CITADEL	<input type="radio"/> 2002	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2003	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2004	<input type="text"/>	<input type="text"/>
	<input type="radio"/> OP SPIRE	<input type="radio"/> 2004	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2005	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2006	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2007	<input type="text"/>	<input type="text"/>
	<input type="radio"/> OP ASTUTE, OP CHIRON, OP TOWER	<input type="radio"/> 2005	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2006	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2007	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2008	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2009	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2010	<input type="text"/>	<input type="text"/>



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**Section Ten: Brief Deployment History**

COUNTRY	OPERATION NAME	YEAR(S) DEPLOYMENT(S) STARTED	NO. OF TIMES DEPLOYED IN YEAR	TOTAL TIME DEPLOYED (MONTHS)
<input type="radio"/> Bougainville	<input type="radio"/> OP BEL ISI I	<input type="radio"/> 1997	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 1998	<input type="text"/>	<input type="text"/>
	<input type="radio"/> OP BEL ISI II	<input type="radio"/> 1999	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2000	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2001	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2002	<input type="text"/>	<input type="text"/>
		<input type="radio"/> 2003	<input type="text"/>	<input type="text"/>

10.2 What other Operations have you been deployed on (war like, peacekeeping, peace-monitoring or humanitarian support), including UN missions (e.g. OP Palate, OP Riverbank), Humanitarian Missions (e.g. OP Pakistan Assist, OP Sumatra Assist), secondments to foreign militaries (e.g. OP Enduring Freedom, OP Herrick), and border protection (e.g. Op Resolute)?

COUNTRY	OPERATION NAME	YEAR(S) DEPLOYMENT(S) STARTED	NO. OF TIMES DEPLOYED IN YEAR	TOTAL TIME DEPLOYED (MONTHS)

10.3 Have you worked in the Middle East in a role outside of the ADF (e.g. as a security contractor or for an NGO)?  Yes  No

**Thank you for completing this questionnaire. Your participation is appreciated.**