**(Revised 6/13/24)**

# ANXIETY CLINIC OF

# WASHBURN UNIVERSITY

**PRE-TREATMENT**

**ASSESSMENT PACKAGE**

 **Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **For Clinical Use Only** |

1. Please **place your initials at the top of each page.**
2. Please **read the instructions** within the shaded box at the top of each page before proceeding with the next set of questions.
3. **Note**: Some questions will probably feel more applicable to you than others. Thank you for your cooperation.

## Client Information

**IDENTIFYING INFORMATION:**

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender Identity\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_ Race/Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religious affiliation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexual Orientation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pronouns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OCCUPATION/EMPLOYMENT INFORMATION:**

Check all that apply: □ employed □ retired □disabled □student □ homemaker □ unemployed

If/When employed, what type of work do you do?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years on Current Job:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ever in Military Service: □ yes □ no Currently in military? □ yes □ no Branch:

**RELATIONSHIP STATUS:**

Relationship status □ Single; □ Married/Committed Partnership; □ Separated/Divorced; □ Widowed; □ Other: \_\_\_\_\_

Are you experiencing any problems/stresses in your current romantic relationship? □ yes □ no

Did you experience any problems/stresses in your previous romantic relationship? □ yes □ no

Comments regarding stresses in current or previous marriage(s)/relationship(s):

Describe your social network (number of friends and degree of closeness with each). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EDUCATION:**

Last grade completed in school/college is/was : Degree:

Are you currently enrolled in school? □ yes □ no Major/focus:

Describe any difficulties or problems you had/have in school:

# REASON FOR SEEKING TREATMENT:

Please briefly describe the problems you are experiencing. A therapist will discuss this in more detail with you shortly.

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**HISTORY OF TREATMENT:**

Have you ever had previous therapy/counseling of any kind? □ yes □ no If yes, when and for how long?

What concerns did you address in previous therapy?

Have you ever been hospitalized for emotional problems? □ yes □ no

Have you ever been treated or hospitalized for substance abuse problems? □ yes □ no

Were any of your previous treatment experiences helpful? □ yes □ no

Please explain how you benefited or did not benefit from previous treatment and why:

**FAMILY BACKGROUND:**

Who lives with you?

List any children and their ages/genders:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your relationships with family members:

Relationship Living? Frequency of contact? Describe quality of relationship

Father □ yes □ no □ n/a

Mother □ yes □ no □ n/a

Step-father □ yes □ no □ n/a

Step-mother □ yes □ no □ n/a

Spouse/partner □ yes □ no □ n/a

Sibling □ yes □ no □ n/a

Sibling □ yes □ no □ n/a

Sibling □ yes □ no □ n/a

Sibling □ yes □ no □ n/a

Other □ yes □ no □ n/a

What family member(s) are you closest to now?

Check the statement(s) below that describe the type of family you grew up in:

□ overly close family □ no “breathing room” □ everyone was in everyone else’s business

□ no privacy □ boundaries not respected □ comfortably close family

□ shared many positive experiences □ supportive □ distant, everyone did their own thing

□ not much time spent together □ not a lot of support □ angry, lots of fighting/hostility

□ verbal abuse and conflicts □ violence □ frightening

□ scared to make mistakes

□ loving

□ other descriptors:

Has any one in your family ever attempted or committed suicide? □ yes □ no

If yes, please explain:

**IN CASE OF EMERGENCY, PLEASE NOTIFY:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street, Apt #) (City) (State) (Zip Code)

Phone: Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Landline \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# HEALTH/MEDICAL INFORMATION:

Physician Approx Date of last visit

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a serious head injury? □ yes □ no If so, describe:

Please list any other significant medical problems/conditions/injuries (e.g., diabetes, cancer, chronic fatigue, arthritis, cardiovascular issues, musculoskeletal issues, gastrointestinal issues, etc.):

List all medications that you currently use:

Medication(s)

Dosage (amount and times per day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any “alternative” therapies/treatments you are currently using and the reason for each:

Initials: \_\_\_\_\_\_\_\_\_\_

**DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure**

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past **TWO (2) WEEKS.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |   During the past **TWO (2) WEEKS**, how much (or how often) have you been  bothered by the following problems? | **None**Not at all | **Slight**Rare, less  than a day or two | **Mild**Several days | **Moderate** More than half the  days | **Severe** Nearly every  day | **Highest  Domain Score**(clinician) |
| I.  | 1. Little interest or pleasure in doing things?  | 0  | 1  | 2  | 3  | 4 |  |
| 2. Feeling down, depressed, or hopeless?  | 0  | 1  | 2  | 3  | 4 |
| II.  | 3. Feeling more irritated, grouchy, or angry than usual?  | 0  | 1  | 2  | 3  | 4 |  |
| III.  | 4. Sleeping less than usual, but still have a lot of energy?  | 0  | 1  | 2  | 3  | 4 |  |
| 5 5. Starting lots more projects than usual or doing more risky things than  usual? | 0  | 1  | 2  | 3  | 4 |
| IV.  | 6. Feeling nervous, anxious, frightened, worried, or on edge?  | 0  | 1  | 2  | 3  | 4 |  |
| 7. Feeling panic or being frightened?  | 0  | 1  | 2  | 3  | 4 |
| 8. Avoiding situations that make you anxious?  | 0  | 1  | 2  | 3  | 4 |
| V.  | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?  | 0  | 1  | 2  | 3  | 4 |  |
| 10. Feeling that your illnesses are not being taken seriously enough?  | 0  | 1  | 2  | 3  | 4 |
| VI.  | 11. Thoughts of actually hurting yourself?  | 0  | 1  | 2  | 3  | 4 |  |
| VII.  | 1 12. Hearing things other people couldn’t hear, such as voices even when no  one was around? | 0  | 1  | 2  | 3  | 4 |  |
| 1 13. Feeling that someone could hear your thoughts, or that you could hear  what another person was thinking? | 0  | 1  | 2  | 3  | 4 |
| III. | V 14. Problems with sleep that affected your sleep quality  over all?  | 0  | 1  | 2  | 3  | 4 |  |
| IX.  | 1 15. Problems with memory (e.g., learning new information) or with location  (e.g., finding your way home)? | 0  | 1  | 2  | 3  | 4 |  |
| X.  | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?  | 0  | 1  | 2  | 3  | 4 |  |
| 1 17. Feeling driven to perform certain behaviors or mental acts over and over again? | 0  | 1  | 2  | 3  | 4 |
| XI.  | 1 18. Feeling detached or distant from yourself, your body, your physical  surroundings, or your memories? | 0  | 1  | 2  | 3  | 4 |  |
| XII.  | 19. Not knowing who you really are or what you want out of life?  | 0  | 1  | 2  | 3  | 4 |  |
| 20. Not feeling close to other people or enjoying your relationships with them?  | 0  | 1  | 2  | 3  | 4 |
| XIII.  | XII 21. Drinking at least 4 drinks of any kind of alcohol in asingle day? | 0  | 1  | 2  | 3  | 4 |  |
| 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?  | 0  | 1  | 2  | 3  | 4 |
|  23. Using any of the following medicines ON YOUR OWN, that is, without a  doctor’s prescription, in greater amounts or longer than prescribed [e.g.,  painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or  tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine  or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin,  inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0  | 1  | 2  | 3  | 4 |

Initials: \_\_\_\_\_\_\_\_\_\_

**ACE-Q**

**Instructions:** Fill in either the 0 or 1 bubble for each item. While you were growing up, during your first 18 years of life:

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **No** | **Yes** |
|  | Did a parent or other adult in the household often…  Swear at you, insult you, put you down, or humiliate you?  or  Act in a way that made you afraid that you might be physically hurt? |  🄋 |  ➀ |
|  | Did a parent or other adult in the household often…  Push, grab, slap, or throw something at you?  or  Ever hit you so hard that you had marks or were injured? |  🄋 |  ➀ |
| **3.** | Did an adult or person at least 5 years older than you ever…  Touch or fondle you or have you touch their body in a sexual way?  or  Try to or actually have oral, anal, or vaginal sex with you? |  🄋 |  ➀ |
| **4.** | Did you often feel that…  No one in your family loved you or thought you were important or special?  or  Your family didn’t look out for each other, feel close to each other, or support each other? |  🄋 |  ➀ |
| **5.** | Did you often feel that…  You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?  or  Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? |  🄋 |  ➀ |
| **6.** | Were your parents ever separated or divorced?  |  🄋 |  ➀ |
| **7.** | Was your mother or stepmother:  Often pushed, grabbed, slapped, or had something thrown at her?  or  Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?  or  Ever repeatedly hit over at least a few minutes or threatened with a gun or knife? |  🄋 |  ➀ |
| **8.** | Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?  |  🄋 |  ➀ |
| **9.** | Was a household member depressed or mentally ill or did a household member attempt suicide?  |  🄋 |  ➀ |
| **10.** | Did a household member go to prison?  |  🄋 |  ➀ |

Initials: \_\_\_\_\_\_\_\_\_

####  ASI-3

|  |
| --- |
| **Instructions:** Fill in the bubble from the scale below that best describes how typical or characteristic each of the 18 items is of ***you***. You should make your ratings in terms of how much you agree or disagree with the statement as a ***general*** description of yourself.  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Very Little** | **A** **Little** |  **Some** | **Much** | Very Much |
| **1.** It is important for me not to appear nervous. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃  |
| **2.** When I cannot keep my mind on a task, I worry that I might be going crazy. |  🄋 |  ➀ |  ➁ |  ➂  |  ➃ |
| **3.** It scares me when my heart beats rapidly. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **4.** When my stomach is upset, I worry that I might be seriously ill. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **5.** It scares me when I am unable to keep my mind on a task. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **6.** When I tremble in the presence of others, I fear what people might think of me. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **7.** When my chest feels tight, I get scared that I won’t be able to breathe properly. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **8.** When I feel pain in my chest I worry that I’m going to have a heart attack. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **9.** I worry that other people will notice my anxiety. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **10.** When I feel “spacey” or spaced out I worry that I may be mentally ill. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **11.** It scares me when I blush in front of people.  |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **12.** When I notice my heart skipping a beat, I worry that there is something seriously wrong with me. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **13.** When I begin to sweat in a social situation, I fear people will think negatively of me. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **14 .** When my thoughts seem to speed up, I worry that I might be going crazy. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **15.** When my throat feels tight, I worry that I could choke to death. |  🄋 |  ➀ |  ➁ |  ➂  |  ➃ |
| **16.** When I have trouble thinking clearly, I worry that there is something wrong with me. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **17.** I think it would be horrible for me to faint in public. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| **18.** When my mind goes blank, I worry there is something terribly wrong with me. |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |

Initials: \_\_\_\_\_\_\_\_\_\_

**BDI**

**Instructions:** On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! If several statements in the group seem to apply equally well, you may select more than one. **Be sure to read all the statements in each group before making your choice.**

 **1** 🄋 I do not feel sad.

 ➀I feel sad.

 ➁ I am sad all the time and I can't snap out of it.

 ➂ I am so sad or unhappy that I can't stand it.

 **2** 🄋 I am not particularly discouraged about the future.

 ➀ I feel discouraged about the future.

 ➁ I feel I have nothing to look forward to.

 ➂ I feel that the future is hopeless and that things

 cannot improve.

 **3** 🄋 I do not feel like a failure.

 ➀ I feel that I have failed more than the average person.

 ➁ As I look back on my life, all I can see is a lot of failures.

 ➂ I feel I am a complete failure as a person.

 **4** 🄋 I get as much satisfaction out of things as I used to.

 ➀ I don't enjoy things the way I used to.

 ➁ I don't get real satisfaction out of anything anymore.

 ➂ I am dissatisfied or bored with everything.

 **5** 🄋 I don't feel particularly guilty.

 ➀ I feel guilty a good part of the time.

 ➁ I feel quite guilty most of the time.

 ➂ I feel guilty all of the time.

 **6** 🄋 I don't feel I am being punished.

 ➀ I feel I may be punished.

 ➁ I expect to be punished.

 ➂ I feel I am being punished.

 **7** 🄋 I don't feel disappointed in myself.

 ➀ I am disappointed in myself.

 ➁ I am disgusted with myself.

 ➂ I hate myself.

 **8** 🄋 I don't feel I am any worse than anybody else.

 ➀ I am critical of myself for my weaknesses or mistakes.

 ➁ I blame myself all the time for my faults.

 ➂ I blame myself for everything bad that happens.

 **9** 🄋 I don't have any thoughts of killing myself.

 ➀ I have thoughts of killing myself, but I would not

 carry them out.

 ➁ I would like to kill myself.

 ➂ I would kill myself if I had the chance.

 **10**🄋 I don't cry any more than usual.

 ➀ I cry more now than I used to.

 ➁ I cry all the time now.

 ➂ I used to be able to cry, but now I can't cry even

 though I want to.

 **11**🄋 I am no more irritated now than I ever am.

 ➀ I get annoyed or irritated more easily than I used to.

 ➁ I feel irritated all the time now.

 ➂ I don’t get irritated at all by the things that used to

 irritate me.

**12** 🄋 I have not lost interest in other people.

 ➀ I am less interested in other people than I used to be.

 ➁ I have lost most of my interest in other people.

 ➂ I have lost all of my interest in other people.

**13** 🄋 I make decisions about as well as I ever could.

 ➀ I put off making decisions more than I used to.

 ➁ I have greater difficulty in making decisions than before.

 ➂ I can't make decisions at all anymore.

**14** 🄋 I don't feel I look any worse than I used to.

 ➀ I am worried that I am looking old or unattractive.

 ➁ I feel that there are permanent changes in my

 appearance that make me look unattractive.

 ➂ I believe that I look ugly.

**15** 🄋 I can work about as well as before.

 ➀ It takes an extra effort to get started at doing something.

 ➁ I have to push myself very hard to do anything.

 ➂ I can't do any work at all.

**16** 🄋 I can sleep as well as usual.

 ➀ I don't sleep as well as I used to.

 ➁ I wake up 1-2 hours earlier than usual and find it hard

 to get back to sleep.

 ➂ I wake up several hours earlier than I used to and

 cannot get back to sleep.

**17** 🄋 I don't get more tired than usual.

 ➀ I get tired more easily than I used to.

 ➁ I get tired from doing almost anything.

 ➂ I am too tired to do anything.

**18** 🄋 My appetite is no worse than usual.

 ➀ My appetite is not as good as it used to be.

 ➁ My appetite is much worse now.

 ➂ I have no appetite at all anymore.

**19** 🄋 I haven't lost much weight, if any, lately.

 ➀ I have lost more than 5 pounds.

 ➁ I have lost more than 10 pounds.

 ➂ I have lost more than 15 pounds*.*

 *I am purposely trying to lose weight by eating less*

 *Yes*  *No*

**20** 🄋 I am no more worried about my health than usual.

 ➀ I am worried about physical problems such as aches

 and pains; or upset stomach; or constipation.

 ➁ I am very worried about physical problems and its

 hard to think about much else.

 ➂ I am so worried about my physical problems that I

 cannot think about anything else.

**21** 🄋 I have not noticed any recent change in my interest in sex.

 ➀ I am less interested in sex than I used to be.

 ➁ I am much less interested in sex now.

 ➂ I have lost interest in sex completely.

Initials: \_\_\_\_\_\_\_\_

# PSWQ

**Instructions:** Please rate your answer according to how typical or characteristic each statement is of you.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not at all Typical** |  |  |  | **Very Typical** |
| **1.** If I don’t have enough time to do everything, I don’t worry about it. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **2.** My worries overwhelm me. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **3.** I don’t tend to worry about things. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **4.** Many situations make me worry. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **5.** I know I shouldn’t worry about things, but I just can’t help it. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **6.** When I am under pressure I worry a lot. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **7.** I am always worrying about something. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **8.** I find it easy to dismiss worrisome thoughts. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **9.** As soon as I finish one task I start to worry about everything else I have to do. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **10.** I never worry about anything. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **11.** When there is nothing more I can do about a concern, I don’t worry about it any more. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **12.** I’ve been a worrier all my life. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **13.** I notice that I have been worrying about things. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **14.** Once I start worrying, I can’t stop. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **15.** I worry all the time. | ➀ | ➁ | ➂ | ➃ | ⑤ |
| **16.** I worry about projects until they are all done. | ➀ | ➁ | ➂ | ➃ | ⑤ |

# Initials: \_\_\_\_\_\_\_\_\_

## SDS

**Instructions:** Select the answer that best describes your situation **now.**

**1.**

WORK

*BECAUSE OF MY PROBLEMS, MY WORK IS IMPAIRED...*

 🄋 ➀ ➁ ➂ ➃ ➄ ➅ ➆ ➇ ➈ ➉

 Not at Mildly Moderately Markedly Very

 All Severely

 (Cannot Work)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2.**

SOCIAL LIFE/LEISURE ACTIVITIES

(with other people at parties, socializing, visiting, dating, outings, clubs, and entertaining)

*BECAUSE OF MY PROBLEMS, MY SOCIAL LIFE/LEISURE IS IMPAIRED...*

 🄋 ➀ ➁ ➂ ➃ ➄ ➅ ➆ ➇ ➈ ➉

 Not at Mildly Moderately Markedly Very

 All Severely

 (I never do these)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3.**

FAMILY LIFE/HOME RESPONSIBILITIES

 (For example, relating to family members, paying bills, managing home, shopping and cleaning.)

*BECAUSE OF MY PROBLEMS, MY FAMILY LIFE/HOME RESPONSIBILITIES ARE IMPAIRED...*

 🄋 ➀ ➁ ➂ ➃ ➄ ➅ ➆ ➇ ➈ ➉

 Not at Mildly Moderately Markedly Very

 All Severely

 (I never do these)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.**

WORK & SOCIAL DISABILITY SCALE

Mark the item that best describes your disability.

PLEASE FILL IN ONE NUMBERED BUBBLE BETWEEN 1 AND 5

Score Definition

* Symptoms radically change or prevent normal work or social activities.

 ➃ Symptoms interfere with normal work or social activities markedly but they are not prevented or

 radically changed.

* Symptoms interfere with normal work or social activities in minor ways.
* Symptoms mild, but not interfering with normal work or social activities.

 ➀ No complaints, normal activity.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Initials: \_\_\_\_\_\_\_

#### SIAS

 **Instructions:** For each question, please indicate the degree to which you feel the statement is characteristic or true of you. The rating scale is as follows:

 **0 = Not at all** characteristic or true of me

 **1 = Slightly** characteristic or true of me

 **2 = Moderately** characteristic or true of me

 **3 = Very** characteristic or true of me

 **4 = Extremely** characteristic or true of me

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not at All** | **Slightly** | **Moderately** | **Very** |  Extremely |
| 1. I get nervous if I have to speak with someone

 in authority (teacher, boss). |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I have difficulty making eye-contact with others.
 |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I become tense if I have to talk about myself or my feelings.
 |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I find it difficult mixing comfortably with the people I work with.

  |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I find it easy to make friends of my own age.
 |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I tense up if I meet an acquaintance in the street.
 |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. When mixing socially, I am uncomfortable.
 |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I feel tense if I am alone with just one person.
 |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I am at ease meeting people at parties, etc.
 |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I have difficulty talking with other people.
 |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I find it easy to think of things to talk about.
 |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I worry about expressing myself in case I appear awkward.

  |  🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I find it difficult to disagree with another's point of view.
 | 🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I have difficulty talking to someone I’m attracted to.
 | 🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I find myself worrying that I won't know what to say in social situations.
 | 🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I am nervous mixing with people I don’t know well.

  | 🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I feel I'll say something embarrassing when talking.

  | 🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. When mixing in a group, I find myself worrying I will be ignored.
 | 🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I am tense mixing in a group.
 | 🄋 |  ➀ |  ➁ |  ➂ |  ➃ |
| 1. I am unsure whether to greet someone I know
 | 🄋 |  ➀ |  ➁ |  ➂ |  ➃ |