



Site ID:

Age

Client ID:

Gender: M F

Therapist ID:

Stage Completed:

- S Screening
- R Referral
- A Assessment
- F First Therapy Session
- P Pre-therapy (unspecified)
- D During Therapy
- L Last therapy session
- X Follow up 1
- Y Follow up 2

Stage

Episode

Date form given

D D M M Y Y Y Y

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been **OVER THE LAST WEEK**.
 Please read each statement and think how often you felt that way last week.
 Then tick the box which is closest to this.

Over the last week ...

| | Not at all | Only occasionally | Sometimes | Often | Most or all the time | OFFICE USE ONLY |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 I have felt terribly alone and isolated | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> F |
| 2 I have felt tense, anxious or nervous | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> P |
| 3 I have felt I have someone to turn to for support when needed | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> F |
| 4 I have felt O.K. about myself | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> W |
| 5 I have felt totally lacking in energy and enthusiasm | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> P |
| 6 I have been physically violent to others | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> R |
| 7 I have felt able to cope when things go wrong | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> F |
| 8 I have been troubled by aches, pains or other physical problems | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> P |
| 9 I have thought of hurting myself | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> R |
| 10 Talking to people has felt too much for me | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> F |
| 11 Tension and anxiety have prevented me doing important things | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> P |
| 12 I have been happy with the things I have done | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> F |
| 13 I have been disturbed by unwanted thoughts and feelings | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> P |
| 14 I have felt like crying | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> W |

Please turn over

004_F_IC_CORE_1022

Over the last week ...

| | Not at all | Only occasionally | Sometimes | Often | Most or all the time | OFFICE USE ONLY |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 15 I have felt panic or terror | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> P |
| 16 I made plans to end my life | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> R |
| 17 I have felt overwhelmed by my problems | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> W |
| 18 I have had difficulty getting to sleep or staying asleep | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> P |
| 19 I have felt warmth or affection for someone | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> F |
| 20 My problems have been impossible to put to one side | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> P |
| 21 I have been able to do most things I needed to | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> F |
| 22 I have threatened or intimidated another person | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> R |
| 23 I have felt despairing or hopeless | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> P |
| 24 I have thought it would be better if I were dead | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> R |
| 25 I have felt criticised by other people | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> F |
| 26 I have thought I have no friends | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> F |
| 27 I have felt unhappy | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> P |
| 28 Unwanted images or memories have been distressing me | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> P |
| 29 I have been irritable when with other people | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> F |
| 30 I have thought I am to blame for my problems and difficulties | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> P |
| 31 I have felt optimistic about my future | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> W |
| 32 I have achieved the things I wanted to | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | <input type="checkbox"/> F |
| 33 I have felt humiliated or shamed by other people | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> F |
| 34 I have hurt myself physically or taken dangerous risks with my health | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> R |

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Total Scores

→ →

↓ ↓ ↓ ↓ ↓ ↓

Mean Scores
 (Total score for each dimension divided by number of items completed in that dimension)

(W) (P) (F) (R) All items All minus R