

Please answer the questions below:

Are you court ordered to be here for treatment due to having a Serious Mental Illness? **Y/N** If yes, what diagnosis and what court? _____

Are you exiting the Utah State Hospital? **Y/N**

Have you been in the hospital in the past 7 days? **Y/N** If yes, where? _____

Have you been in the hospital in the past 30 days? **Y/N** If yes, where? _____

Are you participating in Home Court? **Y/N**

Have you been incarcerated in past 14 days? **Y/N**

Are you pregnant? **Y/N**

Do you use substances intravenously (IV)? **Y/N**

Do you have children? **Y/N**

Are you positive for HIV? **Y/N**

Are you on Intensive Supervision Probation (ISP)? **Y/N**

Have you pled into Family Recovery Court? **Y/N**

Are you in any type of drug court or mental health court? **Y/N** – if yes, please specify: _____

Do you have Medicaid? **Y/N**

Our facility includes onsite childcare, as a result, we are required to follow state safety laws. Do you have any legal restrictions - such as being on the sex offender registry or being prohibited from entering areas where children are present—that would prevent you from accessing this location? **Y/N** – if yes, please specify: _____

	Past month	
	YES	NO
C-SSRS Suicidal Ideation Severity		
1) <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) <u>Have you actually had any thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) <u>Have you been thinking about how you might do this?</u> E.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."		
4) <u>Have you had these thoughts and had some intention of acting on them?</u> As opposed to "I have the thoughts but I definitely will not do anything about them."		
5) <u>Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?</u>		

	YES	NO
	6) <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Took pills, tried to shoot yourself, cut yourself, or hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. If YES, ask: <u>Was this within the past three months?</u>	

Low Risk

Moderate Risk

High Risk

New Client Information

Today's Date: _____ Who referred you to Volunteers of America, Utah? _____

Client Name: _____ Preferred Name: _____
First Middle Last

Date of Birth: _____ Age: _____ Primary Language Spoken at Home: _____ Religious Preference: _____

Do you have insurance? Yes No If yes, what type: _____

Address: _____
Street Apt. # City State Zip code

Are you currently homeless? Yes No

SSN: _____ Email: _____

Phone Number: _____ Alternate Phone Number (specify): _____

Is it okay to leave email and text reminders for appointments? Yes No

Is it okay to leave a voicemail? Yes No

Emergency Contact: _____
Name Relationship

Phone Number Email

Are you currently on probation/parole? Yes No If yes, where? _____

Do you have any pending legal charges? Yes No

Is the client a minor? Yes No If no, skip to next page

Name of Parent/Guardian: _____ Relationship to client: _____

Legal Custody Status: Sole Joint Legal Guardian Foster Adoptive

Do you have medical decision-making authority for the child in your custody? Yes No

Grade Level and School Name: _____

Does child have IEP? Yes No Is child involved in counseling services at school? Yes No

Do you have involvement with Children's Protective Services (CPS) or Division of Child and Family Services (DCFS)?
 Yes No

If Yes, Describe: _____

Name of caseworker assigned to family (if applicable): _____

Demographics

Preferred Pronoun: She/Her He/Him They/Them/Theirs Other: _____

Assigned Gender: Male Female

Gender Expression: Male Female Transgender Gender non-conforming Other: _____

Sexual Orientation: Heterosexual (straight) Gay/ Lesbian Bisexual Asexual Queer Pansexual Other: _____

Race: American Indian Black or African American Alaskan Native Caucasian (White) Chinese Vietnamese
 Korean Filipino Japanese Native Hawaiian Tongan Samoan Other _____

Ethnicity: Are you Hispanic? Yes No Refused If Yes: Central American Cuban Dominican
Mexican Puerto Rican South American Other: _____

Marital Status: Single/never married Married Widowed Separated Divorced Life Partner

Employment Status: Employed full-time Retired Unemployed, looking for work
 Employed part-time Homemaker Unemployed, not looking for work
 PT, looking for FT Student Unemployed, Disabled

Living Arrangement: Owned or rented house, apartment, or room Transitional Housing
 Someone else's house, apartment, room Group/Foster Home
 Homeless (shelter, street, park, couch surfing) Correctional Facility
 Detox/Inpatient/Residential Treatment Hotel/Motel
 Hospital (medical or psychiatric) Nursing Home
 Veteran's Home Military Base
 Other: _____

Education:

Currently enrolled in school or a job training program? Yes No If yes: Full time Part time

Highest Level of Education Completed (whether or not you received a degree):

Less than 5th Grade 11th grade GED
 7th grade 12th grade Some College _____ (# of years completed)
 8th grade High School Diploma Bachelor's Degree
 9th grade Vocational/technical certification Graduate Work/Degree
 10th grade

Military: Have you ever served in the Armed Forces, the Reserves, or the National Guard? Yes No

Is anyone in your family or someone close to you currently serving on activity duty in or retired/separated from the Armed Forces, the Reserves, or the National Guard? Yes No

NEW CLIENT HEALTH HISTORY

CLIENT INFORMATION

Full/Preferred Name: _____ Age: _____ Date of Birth (DOB): _____
 Allergies: Any medications, foods, or environmental factors? No Yes → List: _____
 If Yes → Reaction/Severity: _____
 How would you describe your overall physical health? Excellent Good Fair Poor

MEDICAL HISTORY

Please check any of these medical problems that you have experienced.

Heart Problems Diabetes Type 1 Type 2 Muscle/Joint Problems Kidney Problems
 High Blood Pressure Thyroid Problems Chronic Pain Asthma, COPD, Sleep Apnea
 High Cholesterol Liver Problems Arthritis Cancer
 Seizures Stomach/Intestinal Problems Vision Problems Dental Problems: _____
 Stroke Acid Reflux/GERD Hearing Problems Other: _____
 Tuberculosis (TB) Negative Positive → Treated? No Yes
 Last TB Test Date: _____ Test Type: Skin Blood Chest X-Ray
 Sexually Transmitted Diseases (STD) No Yes → Type: _____ STD Treated? No Yes
 Hepatitis Hep A, Hep B, Hep C → Treated: No Yes
 IV Drug Use No Yes → Last Use: _____
 Have you ever been unconscious, had a head injury, or experienced a black-out? No Yes → _____
 Any family history of mental/medical history: _____

SEXUAL & REPRODUCTIVE HEALTH

Are you currently sexually active? No Yes Prefer not to answer
 Do you use condoms or other protection during sex? Always Sometimes Never Not applicable
 Are you currently using any form of contraception? Pill Implant IUD Other: _____ None

MEDICATION & SUPPLEMENTS

Please list all prescription medications, over-the-counter drugs, vitamins, or supplements you take. None

Medication:	Dose & Frequency	Medication:	Dose & Frequency

Do you have a medical marijuana card? Yes No If Yes, what is it used for? _____
 Are you up to date on your vaccines? (COVID, Tdap, Flu, HepA, HepB, MMR, Tetanus, VAR etc) Yes No Not Sure

OB GYN HISTORY (WOMEN ONLY)

Are you pregnant NOW? No Yes Unsure If YES, Due Date: _____
 Number of times pregnant: _____ Full term pregnancies: _____ Miscarriages or Abortions: _____ Premature births: _____

NICOTINE USE

Have you ever used nicotine? No Yes If yes, age first used: _____
 Currently using nicotine? No Occasionally Daily Multiple times daily Other: _____
 If Yes – What type and how often? Cigarettes: _____ per day Vaping: _____ hits per day
 Pouches/Chewing Tobacco: _____ per day Other: _____
 Are you interested in quitting? No Yes Not sure

PRIMARY CARE

Do you currently have a doctor/primary care provider (PCP)? No Yes
 If Yes: Provider Name & Clinic: _____ Last visit (month/year if known): _____
 Would you like us to involve your doctor/PCP in your recovery? No Yes → please sign the ROI
 If No, would you like us to connect you with a doctor/PCP? Yes No

LEC-5 Standard

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people.

For each event check one or more of the boxes to the right to indicate that:

- (a) it happened to you personally;
- (b) you witnessed it happen to someone else;
- (c) you learned about it happening to a close family member or close friend;
- (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder);
- (e) you're not sure if it fits; or
- (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

Social Determinants of Health Screening (SDOH)

The Accountable Health Communities Health-Related Social Needs Screening Tool

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. What is your living situation today?

- I have a steady place to live
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. Think about the place you live. Do you have problems with any of the following?

CHOOSE ALL THAT APPLY

- Pests such as bugs, ants, or mice
- Mold
- Lead paint or pipes
- Lack of heat
- Oven or stove not working
- Smoke detectors missing or not working
- Water leaks
- None of the above

Food

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often true
- Sometimes true
- Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- Often true
- Sometimes true
- Never true

Transportation

5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- Yes
- No

Utilities

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- Yes
- No
- Already shut off

Safety

7. How often does anyone, including family and friends, physically hurt you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

8. How often does anyone, including family and friends, insult or talk down to you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

9. How often does anyone, including family and friends, threaten you with harm?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

10. How often does anyone, including family and friends, scream or curse at you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

A score of 11 or more when the numerical values for answers to questions 7-10 are added shows that the person might not be safe.

Financial Strain

11. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

Would you say it is:

- Very hard
- Somewhat hard
- Not hard at all

Employment

12. Do you want help finding or keeping work or a job?

- Yes, help finding work
- Yes, help keeping work
- I do not need or want help

Family and Community Support

13. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?

- I don't need any help
- I get all the help I need
- I could use a little more help
- I need a lot more help

14. How often do you feel lonely or isolated from those around you?

- Never
- Rarely
- Sometimes
- Often
- Always

Education

15. Do you speak a language other than English at home?

- Yes
- No

16. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.

- Yes
- No

Physical Activity

17. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7

18. On average, how many minutes did you usually spend exercising at this level on one of those days?

- 0
- 30
- 60
- 90
- 120
- 150 or greater

Age 18 or older: Less than 150 minutes a week shows an HRSN.

Substance Use

19. How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

20. How many times in the past 12 months have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarettes)?

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

21. How many times in the past year have you used prescription drugs for non-medical reasons?

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

22. How many times in the past year have you used illegal drugs?

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

Mental Health

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

a. Little interest or pleasure in doing things?

- Not at all (0)
- Several days (1)
- More than half the days (2)
- Nearly every day (3)

b. Feeling down, depressed, or hopeless?

- Not at all (0)
- Several days (1)
- More than half the days (2)
- Nearly every day (3)

If you get 3 or more when you add the answers to questions 23a and 23b the person may have a mental health need.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any 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?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Outcome Questionnaire (OQ[®]-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

Name: _____ Age: _____ yrs.
 Sex M F
 ID# _____

Session # _____ Date ____/____/____

	Never	Rarely	Sometimes	Frequently	Almost Always	SD	IR	SR
	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<i>DO NOT MARK BELOW</i>		
1. I get along well with others.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
2. I tire quickly.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
3. I feel no interest in things.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
4. I feel stressed at work/school.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
5. I blame myself for things.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		<input type="checkbox"/>
6. I feel irritated.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
7. I feel unhappy in my marriage/significant relationship.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
8. I have thoughts of ending 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"/>	<input type="checkbox"/>	
9. I feel weak.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
10. I feel fearful.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
12. I find my work/school satisfying.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			<input type="checkbox"/>
13. I am a happy person.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			<input type="checkbox"/>
14. I work/study too much.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
15. I feel worthless.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		<input type="checkbox"/>
16. I am concerned about family troubles.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
17. I have an unfulfilling sex life.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
18. I feel lonely.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
19. I have frequent arguments.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
20. I feel loved and wanted.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		<input type="checkbox"/>	
21. I enjoy my spare time.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		<input type="checkbox"/>	
22. I have difficulty concentrating.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		<input type="checkbox"/>
23. I feel hopeless about the future.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
24. I like myself.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			<input type="checkbox"/>
25. Disturbing thoughts come into my mind that I cannot get rid of.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
26. I feel annoyed by people who criticize my drinking (or drug use)..... (If not applicable, mark "never")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
27. I have an upset stomach.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
28. I am not working/studying as well as I used to.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
29. My heart pounds too much.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		<input type="checkbox"/>
30. I have trouble getting along with friends and close acquaintances.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
31. I am satisfied with my life.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		<input type="checkbox"/>	
32. I have trouble at work/school because of drinking or drug use..... (If not applicable, mark "never")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		<input type="checkbox"/>
33. I feel that something bad is going to happen.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
34. I have sore muscles.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
36. I feel nervous.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
37. I feel my love relationships are full and complete.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		<input type="checkbox"/>	
38. I feel that I am not doing well at work/school.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
39. I have too many disagreements at work/school.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		<input type="checkbox"/>
40. I feel something is wrong with my mind.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		<input type="checkbox"/>
41. I have trouble falling asleep 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"/>		
42. I feel blue.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
43. I am satisfied with my relationships with others.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		<input type="checkbox"/>	
44. I feel angry enough at work/school to do something I might regret.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		
45. I have headaches.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>		<input type="checkbox"/>
						+	+	
						Total=		

Developed by Michael J. Lambert, Ph.D. and Gary M. Buehlingame, Ph.D.
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