Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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 figety 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	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. 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 _____

A2663B 10-04-2005

DCCCA Behavioral Health Services
Trauma Checklist Adult

Name _____ Date _____

Listed below are a number of stressful things that sometimes happen to people and reactions which sometimes occur following traumatic events. For each of the following questions, mark YES if the event happened to you and mark NO if this did not happen to you.

1.	Serious accident, fire or explosion		Yes		No
2.	Natural disaster (tornado, flood, hurricane, major earthquake)		Yes		No
3.	Non-sexual assault by someone you know (physically attacked/injured)		Yes		No
4.	Non-sexual assault by a stranger		Yes		No
5.	Sexual assault by a family member or someone you knew		Yes		No
6.	Sexual assault by a stranger		Yes		No
7.	Military combat or a war zone		Yes		No
8.	Sexual contact before you were age 18 with someone who was 5 or more years older than you		Yes		No
9.	Imprisonment		Yes		No
10.	Torture		Yes		No
11.	Life-threatening illness		Yes		No
12.	Chronic health condition		Yes		No
13.	Other traumatic event		Yes		No
14.	If "other traumatic event is checked YES above, please write what the event was				
15.	Of the question(s) to which you answered YES, which was the worst? (Please list question #)				

Please check YES or NO regarding the event listed in question #15				
1. Were you physically injured?		Yes		No
2. Was someone else physically injured?		Yes		No
3. Did you think your life was in danger?		Yes		No
4. Did you think someone else's life was in danger?		Yes		No
5. Did you feel helpless?		Yes		No
6. Did you feel terrified?		Yes		No
7. Did you feel that what happened was disgusting or gross?		Yes		No

DCCCA Staff Initials _____

DCCCA Behavioral Health Services
Trauma Checklist Adult, continued

Name _____ Date _____

Below is a list of problems that people sometimes have after experiencing a traumatic event. Please rate on a scale from 0-3 how much or how often these following things have occurred to you:

0=Never 1=Once in a while 2=Half the time 3=Almost always		Never	Once in a while	Half the time	Almost always
1.	Having upsetting thought or images about the traumatic event that come into you head when you did not want them to.	0	1	2	3
2.	Having bad dreams or nightmares.	0	1	2	3
3.	Reliving the traumatic event (acting or feeling as if it were happening again).	0	1	2	3
4.	Feeling upset when you are reminded of the event.	0	1	2	3
5.	Having feelings in your body when reminded of the event (sweating, upset stomach, increased heart rate, headaches, etc.).	0	1	2	3
6.	Trying not to think, talk, or have feelings about the event.	0	1	2	3
7.	Trying to avoid activities, people, or places that remind you of the event.	0	1	2	3
8.	Not being able to remember an important part of the upsetting event.	0	1	2	3
9.	Having much less interest or participating much less often in things you used to do.	0	1	2	3
10.	Not feeling too close to people around you.	0	1	2	3
11.	Feeling emotionally numb (unable to cry or have loving feelings).	0	1	2	3
12.	Feeling as if your future hopes or plans will not come true.	0	1	2	3
13.	Having trouble falling or staying asleep.	0	1	2	3
14.	Feeling irritable or having fits of anger.	0	1	2	3
15.	Having trouble concentrating.	0	1	2	3
16.	Being overly careful (checking to see who is around).	0	1	2	3
17.	Being jumpy or easily startled.	0	1	2	3

Total: _____

Please mark YES or NO if the problems you marked interfered with:				
1. Work		Yes		No
2. Household duties		Yes		No
3. Friendships		Yes		No
4. Fun/leisure activities		Yes		No
5. Schoolwork		Yes		No
6. Family relationships		Yes		No
7. Sex life		Yes		No
8. General life satisfaction		Yes		No
9. Overall functioning		Yes		No

DCCCA Staff Initials _____

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

12-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page...

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In the past 30 days, how much difficulty did you have in:						
S6	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days*** ____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	***Record number of days*** ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	***Record number of days*** ____

This completes the questionnaire. Thank you.

CASAA Research Division*
8/95

Personal Drinking Questionnaire
(SOCRATES 8A)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drinking*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

	NO! Strongly Disagree	**No** Disagree	**?** Undecided or Unsure	**Yes** Agree	**YES!** Strongly Agree
1. I really want to make changes in my drinking.	**1**	**2**	**3**	**4**	**5**
2. Sometimes I wonder if I am an alcoholic.	**1**	**2**	**3**	**4**	**5**
3. If I don't change my drinking soon, my problems are going to get worse.	**1**	**2**	**3**	**4**	**5**
4. I have already started making some changes in my drinking.	**1**	**2**	**3**	**4**	**5**
5. I was drinking too much at one time, but I've managed to change my drinking.	**1**	**2**	**3**	**4**	**5**
6. Sometimes I wonder if my drinking is hurting other people.	**1**	**2**	**3**	**4**	**5**
7. I am a problem drinker.	**1**	**2**	**3**	**4**	**5**
8. I'm not just thinking about changing my drinking, I'm already doing something about it.	**1**	**2**	**3**	**4**	**5**
9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.	**1**	**2**	**3**	**4**	**5**
10. I have serious problems with drinking.	**1**	**2**	**3**	**4**	**5**

	NO! Strongly Disagree	**No** Disagree	**?** Undecided or Unsure	**Yes** Agree	**YES!** Strongly Agree
11. Sometimes I wonder if I am in control of my drinking.	**1**	**2**	**3**	**4**	**5**
12. My drinking is causing a lot of harm.	**1**	**2**	**3**	**4**	**5**
13. I am actively doing things now to cut down or stop drinking.	**1**	**2**	**3**	**4**	**5**
14. I want help to keep from going back to the drinking problems that I had before.	**1**	**2**	**3**	**4**	**5**
15. I know that I have a drinking problem.	**1**	**2**	**3**	**4**	**5**
16. There are times when I wonder if I drink too much.	**1**	**2**	**3**	**4**	**5**
17. I am an alcoholic.	**1**	**2**	**3**	**4**	**5**
18. I am working hard to change my drinking.	**1**	**2**	**3**	**4**	**5**
19. I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink.	**1**	**2**	**3**	**4**	**5**

CASAA Research Division*
9/95

Personal Drug Use Questionnaire
(SOCRATES 8D)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drug use*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

	NO! Strongly Disagree	**No** Disagree	**?** Undecided or Unsure	**Yes** Agree	**YES!** Strongly Agree
1. I really want to make changes in my use of drugs.	**1**	**2**	**3**	**4**	**5**
2. Sometimes I wonder if I am an addict.	**1**	**2**	**3**	**4**	**5**
3. If I don't change my drug use soon, my problems are going to get worse.	**1**	**2**	**3**	**4**	**5**
4. I have already started making some changes in my use of drugs.	**1**	**2**	**3**	**4**	**5**
5. I was using drugs too much at one time, but I've managed to change that.	**1**	**2**	**3**	**4**	**5**
6. Sometimes I wonder if my drug use is hurting other people.	**1**	**2**	**3**	**4**	**5**
7. I have a drug problem.	**1**	**2**	**3**	**4**	**5**
8. I'm not just thinking about changing my drug use, I'm already doing something about it.	**1**	**2**	**3**	**4**	**5**
9. I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern.	**1**	**2**	**3**	**4**	**5**
10. I have serious problems with drugs.	**1**	**2**	**3**	**4**	**5**

	NO! Strongly Disagree	**No** Disagree	**?** Undecided or Unsure	**Yes** Agree	**YES!** Strongly Agree
11. Sometimes I wonder if I am in control of my drug use.	**1**	**2**	**3**	**4**	**5**
12. My drug use is causing a lot of harm.	**1**	**2**	**3**	**4**	**5**
13. I am actively doing things now to cut down or stop my use of drugs.	**1**	**2**	**3**	**4**	**5**
14. I want help to keep from going back to the drug problems that I had before.	**1**	**2**	**3**	**4**	**5**
15. I know that I have a drug problem.	**1**	**2**	**3**	**4**	**5**
16. There are times when I wonder if I use drugs too much.	**1**	**2**	**3**	**4**	**5**
17. I am a drug addict.	**1**	**2**	**3**	**4**	**5**
18. I am working hard to change my drug use.	**1**	**2**	**3**	**4**	**5**
19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before.	**1**	**2**	**3**	**4**	**5**