



Department of Psychiatry
Center for the Treatment and Study of Anxiety
Edna B. Foa, Ph.D.
Professor and Director

Dear Sir/ Madam,

Thank you for your interest in the Open Clinic at the Center for the Treatment and Study of Anxiety (CTSA). The CTSA is an internationally recognized clinic that offers state-of-the-art psychotherapies for anxiety disorders. Currently, we offer treatment programs that have been specifically designed to deal with Obsessive-Compulsive Disorder (OCD), Posttraumatic Stress Disorder (PTSD), Trichotillomania (hair-pulling), Social Anxiety Disorder, Panic Disorder, Agoraphobia, Generalized Anxiety Disorder, and Specific Phobias.

Our faculty members have extensive experience in cognitive-behavioral therapy (CBT), a highly specialized form of psychotherapy that research has shown to be very effective in the treatment of anxiety disorders. In general, therapy at CTSA consists of approximately 10-20 sessions, delivered once or twice per week. However, each patient's treatment is individually tailored based on the information gathered during his or her assessment.

If you have and questions about our assessment or treatment, please contact us at (215) 746-3327, and one of our clinic coordinators will be pleased to speak with you.

I very much want to see that you have a positive experience in our program.

Sincerely,

A handwritten signature in black ink that reads "Edna B. Foa".

Edna B. Foa, Ph.D.
Professor of Clinical Psychology in Psychiatry
Director, Center for the Treatment and Study of Anxiety



Department of Psychiatry
Center for the Treatment and Study of Anxiety
Edna B. Foa, Ph.D.
Professor and Director

Welcome to CTSA

Thank you for choosing to receive services at the Center for the Treatment and Study of Anxiety (CTSA). It is important to us that you feel comfortable and welcome during your time with us. This handout is provided to help you get oriented to our building and to some of our basic procedures.

Parking

The closest parking is available in the garage right before 38th and Market. Other lots are located in the surrounding neighborhood. Fees vary by location and time of day. Metered parking is available on the street.

Building Security

For your protection and the protection of those who work here, the security personnel in the front lobby will ask you to sign in when you arrive and out when you leave the building.

Clinic Procedures

Our office hours are by appointment. Please check in with the receptionist when you arrive. She will notify your therapist that you are here. Have a seat in the waiting area and your therapist will come to call you for your session. If you have any questions please ask the receptionist for help at any time.

Keep in mind that sessions are going on in the offices near the waiting area and that noise can interfere with sessions. Your help in keeping noise to a minimum is appreciated.

Telephone

Our telephone number is 215-746-3327. During office hours our receptionist answers the phone. After working hours, on weekends, and on holidays, an automated voice messaging system will answer the phone. You may leave a message on the voice mail that will be picked up and forwarded to the correct individual the next working day.

If you have an emergency, please call the CTSA beeper at 215-308-2678.

If your emergency is life threatening, please call 911 or go to the nearest emergency room.

Restrooms

Restrooms for our patients and visitors are located in the main hallway. The receptionist will provide you with a key and point you in the right direction.

Near each restroom is a large handicapped accessible restroom for which no key is needed.

Confidentiality

Confidentiality is important at CTSA. Accordingly, we will not communicate with anyone about you without your written permission. If you want us to communicate with your health care provider, spouse, or other designated person, please let us know and we will provide you with a form for giving consent.

Fees

Fees are due in full at the time of each session. The receptionist will accept your payment.

Insurance Reimbursement

CTSA does not submit statements directly to insurance companies. Since each company is different, please check with your insurance company to determine if they will reimburse you. If your health plan includes mental health benefits we will provide you with the information needed to submit for reimbursement.

Cancellations and Missed Appointments

If for some reason you are unable to keep an appointment, please notify your therapist as soon as possible. Our policy is to charge the session fee for missed appointments and for appointments not canceled at least 24 hours in advance. Insurance companies will not typically reimburse for charges due to missed appointments.

DIRECTIONS TO:
The Center for the Treatment and Study of Anxiety
3535 Market Street, 6th Floor
Philadelphia, PA 19104
215-746-3327

FROM NORTHERN SUBURBS:

- Take I-95 South to I-676 West (Central Philadelphia).
- Continue on I-676 West to the junction with I-76.
- Take the exit for I-76 East (toward Philadelphia Airport) and keep right.
- Exit immediately at Exit 345 (old Exit 39) for 30th Street Station.
- At the top of the ramp, turn right, then follow traffic to the left around train station.
- Turn right at the second traffic light onto Market Street.
- Continue on Market Street to 36th Street, where The Center is on the right.

FROM WEST:

- Take I-76 East toward Central Philadelphia.
- Take Exit 345 (old Exit 39) for 30th Street Station.
- At the top of the ramp, turn right, then follow traffic to the left around train station.
- Turn right at the second traffic light onto Market Street.
- Continue on Market Street to 36th Street, where The Center is on the right.

FROM SOUTHERN NEW JERSEY:

VIA BENJAMIN FRANKLIN BRIDGE:

- Take Ben Franklin Bridge into Philadelphia, continue on I-676 West to junction with I-76.
- Take the exit for I-76 East (toward Philadelphia Airport) and keep right.
- Exit immediately at Exit 345 (old Exit 39) for 30th Street Station.
- At the top of the ramp, turn right, then follow traffic to the left around train station.
- Turn right at the second traffic light onto Market Street.
- Continue on Market Street to 36th Street, where The Center is on the right.

VIA WALT WHITMAN BRIDGE:

- Take Walt Whitman Bridge into Philadelphia, continue on I-76 West to Exit 346A-South Street (old Exit 40). ***This exit is from the left lane***
- Turn left at the top of the ramp onto South Street.
- Continue past Franklin Field (football stadium) to the second traffic light.
- Turn right onto 33rd Street.
- Continue on 33rd Street to the third traffic light and turn left onto Market Street.
- The Center is at the corner of 36th and Market on the right.

FROM NORTHERN NEW JERSEY AND NEW YORK:

- Take I-295 South to Exit 27 (I-76, Walt Whitman Bridge, Philadelphia).
- Take Walt Whitman Bridge into Philadelphia, continue on I-76 West to Exit 346A-South Street (old Exit 40). ***This exit is from the left lane***
- Turn left at the top of the ramp onto South Street.
- Continue past Franklin Field (football stadium) to the second traffic light.
- Turn right onto 33rd Street.
- Continue on 33rd Street to the third traffic light and turn left onto Market Street.
- The Center is at the corner of 36th and Market on the right.

FROM PHILADELPHIA INT'L. AIRPORT, DELAWARE COUNTY, AND DELAWARE:

- Take I-95 to I-676 West (Central Philadelphia). ***This exit is from the left lane***
- Continue on I-676 West to the junction with I-76.
- Take exit for I-76 East (toward Philadelphia Airport) and keep right.
- Exit immediately at Exit 345 (old Exit 39) for 30th Street Station.
- At the top of the ramp, turn right, then follow traffic to the left around train station.
- Turn right at the second traffic light onto Market Street.
- Continue on Market Street to 36th Street.
- The Center is at the corner of 36th and Market on the right.

FROM 30th STREET STATION (via AMTRAK or SEPTA Regional Rail Lines):

- From 30th Street Station you can take a taxi or walk six blocks West on Market to 36th and Market Streets. The Center is located on the ride side of Market Street at the corner of 36th Street.
- Alternate: Take the westbound Route 10 subway-surface trolley from the 30th Street Subway Station. Get off at the first stop after the trolley surfaces onto the street, 36th at Market. The center is located on the right side of Market Street, far side of Market Street.

VIA SUBWAY/TROLLEY:

- Take the Market-Frankford subway line to 34th Street Station. Exit the tunnel and walk two blocks west to 36th Street. The Center is on the right side of Market Street at the corner of 36th Street.
- Alternate: Take Market-Frankford subway line to 30th Street station. Change for the westbound Route 10 trolley. Get off at the first stop after the trolley surfaces onto the street, 36th at Market. The Center is located on the right side of 36th Street on the far side of Market.

VIA BUS:

- The Center is located at the northeast corner of 36th and Market Streets. This area is served by the following bus routes:
 - Route 21 at 36th Street and Walnut Street (westbound) or Chestnut Street (eastbound)
 - Routes 30 and 31 at 34th Street and Market Street
 - Route 40 at 36th Street and Spruce Street

PARKING:

In addition to metered street parking, several lots and garages are available in the nearby area:

- 34th Street between Chestnut and Market Streets
- 36th and Chestnut Streets (at the Sheraton Hotel)
- 39th and Market Streets
- Market Street between 36th and 38th Streets

Self-Report Questionnaires

Dear Client,

Thank you very much for taking the time to fill out the questionnaires we have included in this pre-treatment package. These questionnaires have been included to help the intake evaluator make proper diagnoses and design the appropriate treatment program, as well as to assist in ongoing efforts to better understand the symptoms patients experience and help develop more effective treatments. Please follow the directions below when filling out all of the questionnaires.

- 1.) **Please use black or blue ink when filling in the bubbles.**
- 2.) **Please fill in all bubbles completely**

Correct: Is this your first visit to the clinic? Y

Incorrect: Is this your first visit to the clinic? Y or Y or Y

- 3.) **Please fill out all information that is applicable to you.** If you have any questions about the packet, please call prior to your appointment or speak to a staff member on the day of your appointment.

Again, thank you for your time and cooperation.

Sincerely,

Clinical Assessment Coordinator



Demographics

STAFF/FACULTY ONLY

ID NUMBER						VISIT #		MONTH		DAY		YEAR	
0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9	9

To be filled out by Patient:

Name

____/____/____
Today's Date

AGE		YEARS OF EDUCATION	
0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

1. Sex: M F

2. Race (fill in all that apply):

- African Caucasian American Indian
- Hispanic Asian Other, specify _____

3. Relationship status:

- Single Married Separated
- Divorced Spouse deceased Living with partner

4. Highest degree earned:

- High School Diploma Masters M. D.
- Associates Degree Bachelors Degree Doctorate

5. Occupation: _____

6. Employment status:

- Full-time Unemployed-looking for work Homemaker
- Part-time Unemployed-not looking for work Student
- Retired Disabled

7. Income before taxes, in the past year:

- \$0-5,000 \$5,100-10,000 \$10,100-20,000 \$20,100-30,000
- \$30,100-50,000 \$50,100-100,000 \$100,100 plus

8. Religion:

- Buddhist Catholic Hindu
- Moslem Protestant Not Religious
- Jewish

9. How did you hear about The Center for the Treatment and Study of Anxiety?

- Dr. referral, specify _____

- City paper Philadelphia Inquirer
- Metro Metro Kids Philadelphia Weekly
- Radio, specify station _____

- Bus Ad, specify _____

- Book, specify title of book _____

- Friend Talk/Presentation, specify location of talk _____

- Other, please specify _____

MEDICATION RECORD

NAME _____

(Check if applicable)

DATE _____

-Diabetes _____

-Seizure disorder _____

-Allergies _____

-Chronic health problem _____

1) Medication you are currently using

Name of the medication	Total duration of treatment (check one)			Highest dose (mg/day)	Response to treatment (check one)			Date last used mm/dd/yy
	0-2 wk	2-8 wk	>8 wk		Poor	Fair	Good	
1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
6)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
8)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /

2) Medication you are no longer using but have used in the past

Name of the medication	Total duration of treatment (check one)			Highest dose (mg/day)	Response to treatment (check one)			Date last used mm/dd/yy
	0-2 wk	2-8 wk	>8 wk		Poor	Fair	Good	
1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
6)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /
8)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ / /

SMOKING QUESTIONNAIRE

Name: _____

Date: ____/____/____

CURRENT SMOKING STATUS

1. Do you currently smoke cigarettes: YES NO

If your answer is "NO", please skip to number 5.

2. At what age did you start smoking: _____

3. In the past week, what was your average number of cigarettes per day: _____

4. Have you ever tried to quit smoking: YES NO

• If yes, approximately how many times: _____

• Which methods have you tried: _____

Please skip to number 9.

SMOKING HISTORY

5. Did you smoke cigarettes in the past: YES NO

• If yes, how many cigarettes did you smoke per day: _____

If your answer is "NO", please skip to number 9.

6. About how long ago did you stop smoking: years _____ months _____

7. At what age did you start smoking: _____

8. Approximately how many times did you try to quit smoking: _____

Which methods did you try: _____

Which was successful: _____

9. Did your parents smoke: YES NO

• If yes, which parent(s): MOTHER FATHER BOTH



PDS

<u>ID NUMBER</u>	<u>STAFF/FACULTY ONLY</u>	<u>VISIT NUMBER</u>
_____ <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9		_____ <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9
_____ <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9		_____ <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9
_____ <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9		
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_____ <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9		

Part 1

Many people have lived through or witnessed a very stressful and traumatic event at some point in their lives. Below is a list of traumatic events. Fill in the bubble next to ALL of the events that have happened to you or that you have witnessed. If none, fill in here Y

- (1) Y Serious accident, fire, or explosion (for example, an industrial, farm, car, plane, or boating accident)
- (2) Y Natural disaster (for example, tornado, hurricane, flood, or major earthquake)
- (3) Y Non-sexual assault by a family member or someone you know (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)
- (4) Y Non-sexual assault by a stranger (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)
- (5) Y Sexual assault by a family member or someone you know (for example, rape or attempted rape)
- (6) Y Sexual assault by a stranger (for example, rape or attempted rape)
- (7) Y Military combat or war zone
- (8) Y Sexual contact when you were younger than 18 with someone who was 5 or more years older than you (for example, contact with genitals, breasts)
- (9) Y Imprisonment (for example, prison inmate, prisoner of war, hostage)
- (10) Y Torture
- (11) Y Life-threatening illness
- (12) Y Other traumatic event
- (13) Y If you marked item 12, specify the traumatic event here.

IF YOU MARKED ANY OF THE ITEMS ABOVE, CONTINUE.
IF NOT, STOP HERE.

Part 2

(14) If you marked more than one traumatic event in Part 1, fill in the bubble below next to the event *that bothers you the most*. If you marked only one traumatic event in Part 1, fill in the same one below.

- Y Accident
- Y Disaster
- Y Non-sexual assault by family or someone you know
- Y Non-sexual assault by a stranger
- Y Sexual assault by family or someone you know
- Y Sexual assault by a stranger
- Y Combat
- Y Sexual contact under 18 with someone 5 or more years older
- Y Imprisonment
- Y Torture
- Y Life-threatening illness
- Y Other

In the lines below, briefly describe the traumatic event you marked above.

Below are several questions about the traumatic event you just described above.

(15) How long ago did the traumatic event happen? (fill in ONE)

- 1 Less than 1 month
- 2 1 to 3 months
- 3 3 to 6 months
- 4 6 months to 3 years
- 5 3 to 5 years
- 6 More than 5 years

For the following questions, fill in Y for Yes or N for No.
During this traumatic event:

- (16) Y N Were you physically injured?
 (17) Y N Was someone else physically injured?
 (18) Y N Did you think that your life was in danger?
 (19) Y N Did you think that someone else's life was in danger?
 (20) Y N Did you feel helpless?
 (21) Y N Did you feel terrified?

Part 3

Below is a list of problems that people sometimes have after experiencing a traumatic event. Read each one carefully and fill in the number (0-3) that best describes how often that problem has bothered you IN THE PAST MONTH. Rate each problem with respect to the traumatic event you described in Item 14.

- 0 Not at all or only one time
 1 Once a week or less/once in a while
 2 2 to 4 times a week/half the time
 3 5 or more times a week/almost always

- (22) 0 1 2 3 Having upsetting thoughts or images about the traumatic event that came into your head when you didn't want them to
 (23) 0 1 2 3 Having bad dreams or nightmares about the traumatic event
 (24) 0 1 2 3 Reliving the traumatic event, acting or feeling as if it was happening again
 (25) 0 1 2 3 Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, guilty, etc.)
 (26) 0 1 2 3 Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in a sweat, heart beating fast)
 (27) 0 1 2 3 Trying not to think about, talk about, or have feelings about the traumatic event
 (28) 0 1 2 3 Trying to avoid activities, people, or places that remind you of the traumatic event
 (29) 0 1 2 3 Not being able to remember an important part of the traumatic event
 (30) 0 1 2 3 Having much less interest or participating much less often in important activities
 (31) 0 1 2 3 Feeling distant or cut off from people around you

- (32) 0 1 2 3 Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings)
 (33) 0 1 2 3 Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life.
 (34) 0 1 2 3 Having trouble falling or staying asleep
 (35) 0 1 2 3 Feeling irritable or having fits of anger
 (36) 0 1 2 3 Having trouble concentrating (for example, drifting in and out of conversation, losing track of a story on television, forgetting what you read)
 (37) 0 1 2 3 Being overly alert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.)
 (38) 0 1 2 3 Being jumpy or easily startled (for example, when someone walks up behind you)

(39) How long have you been experiencing the problems that you reported above? (fill in ONE)

- 1 Less than 1 month
 2 1 to 3 months
 3 More than 3 months

(40) How long after the traumatic event did these problems begin? (fill in ONE)

- 1 Less than 6 months
 2 6 or more months

Part 4

Indicate below if the problems you rate in Part 3 have interfered with any of the following areas of your life DURING THE PAST MONTH. Fill in Y for Yes and N for No.

- (41) Y N Work
 (42) Y N Household chores and duties
 (43) Y N Relationships with friends
 (44) Y N Fun and leisure activities
 (45) Y N Schoolwork
 (46) Y N Relationships with your family
 (47) Y N Sex life
 (48) Y N General satisfaction with life
 (49) Y N Overall level of functioning in all areas of your life

PDSS – Self-Report



<u>ID NUMBER</u>	<u>STAFF/FACULTY ONLY</u>	<u>VISIT NUMBER</u>
____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
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____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		
____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		

Several of the following questions refer to panic attacks and limited symptom attacks. For this questionnaire, we define a **panic attack** as a sudden rush of fear or discomfort accompanied by at least 4 of the symptoms listed below. In order to qualify as a sudden rush, the symptoms must peak within 10 minutes. Episodes like panic attacks but having fewer than 4 of the listed symptoms are called **limited symptom attacks**. Here are the symptoms to count:

- Rapid or pounding heartbeat
- Sweating
- Trembling or shaking
- Breathlessness
- Feeling of choking
- Chest pain or discomfort
- Nausea
- Dizziness or faintness
- Feelings of unreality
- Numbness or tingling
- Chills or hot flushes
- Fear of losing control or going crazy
- Fear of dying

➤ **From the list above, please fill-in the symptoms you experience during a typical attack**

For each of the following questions, please fill-in the number of the answer that best describes your experience **during the past week**.

1. How many panic and limited symptom attacks did you have during the past week?
 - No panic or limited symptom episodes
 - Mild: no full panic attacks and no more than 1 limited symptom attack/day
 - Moderate: 1 or 2 full panic attacks and/or multiple limited symptom attacks/day
 - Severe: more than 2 full attacks but not more than 1/day on average
 - Extreme: full panic attacks occurred more than once per day, more days than not

PDSS – Self-Report

2. If you had any panic attacks during the past week, how distressing (uncomfortable, frightening) were they while they were happening? (If you had more than one, give an average rating. If you didn't have any panic attacks but did have limited symptom attacks, answer for the limited symptom attacks).
- ① Not at all distressing, or no panic or limited symptom attacks during the past week
 - ② Mildly distressing (not too intense)
 - ③ Moderately distressing (intense, but still manageable)
 - ④ Severely distressing (very intense)
 - ⑤ Extremely distressing (extreme distress during all attacks)
3. During the past week, how much have you worried or felt anxious about when your next panic attack would occur, or about fears related to the attacks (for example, that they could mean you have physical or mental health problems or could cause you social embarrassment)?
- ① Not at all
 - ② Occasionally or only mildly
 - ③ Frequently or moderately
 - ④ Very often or to a very disturbing degree
 - ⑤ Nearly constantly and to a disabling degree
4. During the past week, were there any places or situations (e.g., public transportation, movie theaters, crowds, bridges, tunnels, shopping malls, being alone) you avoided or felt afraid of (uncomfortable in, wanted to avoid or leave), because of fear of having a panic attack? Are there any other situations that you would have avoided or been afraid of if they had come up during the week, for the same reason? If yes to either question, please rate your level of fear and avoidance in the past week.
- ① None: no fear or avoidance
 - ② Mild: occasional fear and/or avoidance, but I usually confront or endure the situation. There was little or no modification of my lifestyle due to this.
 - ③ Moderate: noticeable fear and/or avoidance, but still manageable. I avoided some situations but I could confront them with a companion. There was some modification of my lifestyle because of this, but my overall functioning was not impaired.
 - ④ Severe: extensive avoidance. Substantial modification of my lifestyle was required to accommodate the avoidance, making it difficult to manage usual activities.
 - ⑤ Extreme: pervasive, disabling fear and/or avoidance. Extensive modification in my lifestyle was required, such that important tasks were not performed.

PDSS – Self-Report

5. During the past week were there any activities (e.g., physical exertion, sexual relations, taking a hot shower or bath, drinking coffee, watching an exciting or scary movie) that you avoided or felt afraid of (uncomfortable doing, wanted to avoid or stop) because they caused physical sensations like those you feel during panic attacks or that you were afraid might trigger a panic attack? Are there any other activities that you would have avoided or been afraid of if they had come up during the week, for that reason? If yes to either question, please rate your level of fear and avoidance of those activities in the past week.
- ① No fear or avoidance of situations or activities because of distressing physical sensations.
 - ② Mild: occasional fear and/or avoidance, but usually I could confront or endure with little distress activities that cause physical sensations. There was a little modification of my lifestyle due to this.
 - ③ Moderate: noticeable avoidance, but still manageable. There was definite, but limited, modification of my lifestyle, such that my overall functioning was not impaired.
 - ④ Severe: extensive avoidance. There was substantial modification of my lifestyle or interference in my functioning.
 - ⑤ Extreme: pervasive and disabling avoidance. There was extensive modification in my lifestyle due to this, such that important tasks or activities were not performed.
6. During the past week, how much did the above symptoms altogether (panic and limited symptom attacks, worry about the attacks, and fear of situations and activities because of the attacks), interfere with your ability to work or carry out your responsibilities at home? (If your work or home responsibilities were less than usual this past week, answer how you think you would have done if the responsibilities had been usual).
- ① No interference with work or home responsibilities.
 - ② Slight interference with work or home responsibilities, but I could do nearly everything I could if I didn't have these problems
 - ③ Significant interference with work or home responsibilities, but I could still manage to do the things I needed to do
 - ④ Substantial impairment in work or home responsibilities; there were many important things I couldn't do because of these problems
 - ⑤ Extreme, incapacitating impairment, such that I was essentially unable to manage any work or home responsibilities
7. During the past week, how much did panic and limited symptom attacks, worry about the attacks, and fear of situations and activities because of the attacks, interfere with your social life? (If you didn't have many opportunities to socialize this past week, answer how you think you would have done if you did have opportunities.)
- ① No interference
 - ② Slight interference with social activities, but I could do nearly everything I could if I didn't have these problems
 - ③ Significant interference with social activities, but I could manage to do most things if I made the effort
 - ④ Substantial impairment in social activities; there were many social things I couldn't do because of these problems
 - ⑤ Extreme, incapacitating impairment, such that there was hardly anything social I could do



DASS-21

<u>ID NUMBER</u>	<u>STAFF/FACULTY ONLY</u>	<u>VISIT NUMBER</u>
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		

Name: _____

Date: _____

Please read each statement and fill in the circle 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of the time
- 3 Applied to me very much, or most of the time

- | | | | | |
|--|-----|-----|-----|-----|
| 1 I found it hard to wind down | (0) | (1) | (2) | (3) |
| 2 I was aware of dryness in my mouth | (0) | (1) | (2) | (3) |
| 3 I couldn't seem to experience any positive feeling at all | (0) | (1) | (2) | (3) |
| 4 I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion) | (0) | (1) | (2) | (3) |
| 5 I found it difficult to work up the initiative to do things | (0) | (1) | (2) | (3) |
| 6 I tended to over-react to situations | (0) | (1) | (2) | (3) |
| 7 I experienced trembling | (0) | (1) | (2) | (3) |
| 8 I felt that I was using a lot of nervous energy | (0) | (1) | (2) | (3) |
| 9 I was worried about situations in which I might panic and make a fool of myself | (0) | (1) | (2) | (3) |
| 10 I felt that I had nothing to look forward to | (0) | (1) | (2) | (3) |
| 11 I found myself getting agitated | (0) | (1) | (2) | (3) |

Reminder of rating scale:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of the time
- 3 Applied to me very much, or most of the time

12 I found it difficult to relax	0	1	2	3
13 I felt down-hearted and blue	0	1	2	3
14 I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 I felt I was close to panic	0	1	2	3
16 I was unable to become enthusiastic about anything	0	1	2	3
17 I felt that I wasn't much as a person	0	1	2	3
18 I felt that I was rather touchy	0	1	2	3
19 I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20 I felt scared without any good reason	0	1	2	3
21 I felt that life was meaningless	0	1	2	3



SIAS

<u>ID NUMBER</u>	<u>STAFF/FACULTY ONLY</u>	<u>VISIT NUMBER</u>
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)

Directions: For each question, fill in the appropriate number to indicate the degree to which you feel the statement is characteristic or true of you:

0	1	2	3	4
<i>Not at all</i>	<i>Slightly</i>	<i>Moderately</i>	<i>Very characteristic</i>	<i>Extremely</i>
characteristic or true of me	characteristic or true of me	characteristic or true of me	or true of me	characteristic or true of me

- | | | | | | |
|---|-----|-----|-----|-----|-----|
| 1. I get nervous if I have to speak with someone in authority | (0) | (1) | (2) | (3) | (4) |
| 2. I have difficulty making eye contact with others | (0) | (1) | (2) | (3) | (4) |
| 3. I become tense if I have to talk about myself or my feelings | (0) | (1) | (2) | (3) | (4) |
| 4. I have difficulty mixing comfortably with people I work with | (0) | (1) | (2) | (3) | (4) |
| 5. I find it easy to make friends of my own age | (0) | (1) | (2) | (3) | (4) |
| 6. I tense up if I meet an acquaintance on the street | (0) | (1) | (2) | (3) | (4) |
| 7. When mixing socially, I am uncomfortable | (0) | (1) | (2) | (3) | (4) |
| 8. I feel tense if I am alone with just one person | (0) | (1) | (2) | (3) | (4) |
| 9. I am at ease meeting people at parties, etc. | (0) | (1) | (2) | (3) | (4) |
| 10. I have difficulty talking with other people | (0) | (1) | (2) | (3) | (4) |
| 11. I find it easy to think of things to talk about | (0) | (1) | (2) | (3) | (4) |
| 12. I worry about expressing myself in case I appear awkward | (0) | (1) | (2) | (3) | (4) |
| 13. I find it difficult to disagree with another persons point of view | (0) | (1) | (2) | (3) | (4) |
| 14. I have difficulty talking to attractive persons of the opposite sex | (0) | (1) | (2) | (3) | (4) |
| 15. I find myself worrying that I won't know what to do or say in social situations | (0) | (1) | (2) | (3) | (4) |
| 16. I am nervous mixing with people I don't know well | (0) | (1) | (2) | (3) | (4) |
| 17. I feel I'll say something embarrassing when talking | (0) | (1) | (2) | (3) | (4) |
| 18. When mixing in a group, I find myself worrying I will be ignored | (0) | (1) | (2) | (3) | (4) |
| 19. I am tense mixing in a group | (0) | (1) | (2) | (3) | (4) |
| 20. I am unsure whether to greet someone I know only slightly | (0) | (1) | (2) | (3) | (4) |



OCI-R

<u>ID NUMBER</u>	<u>STAFF/FACULTY ONLY</u>	<u>VISIT NUMBER</u>
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		

The following statements refer to experiences that many people have in their everyday lives. Fill in the number that best describes **HOW MUCH** that experience has **DISTRESSED OR BOTHERED** you during the **PAST MONTH**. The numbers refer to the following verbal labels:

0	1	2	3	4
Not at all	A little	Moderately	A lot	Extremely

- | | | | | | |
|---|-----|-----|-----|-----|-----|
| 1. I have saved up so many things that they get in the way. | (0) | (1) | (2) | (3) | (4) |
| 2. I check things more often than necessary. | (0) | (1) | (2) | (3) | (4) |
| 3. I get upset if objects are not arranged properly. | (0) | (1) | (2) | (3) | (4) |
| 4. I feel compelled to count while I am doing things. | (0) | (1) | (2) | (3) | (4) |
| 5. I find it difficult to touch an object when I know it has been touched by strangers or certain people. | (0) | (1) | (2) | (3) | (4) |
| 6. I find it difficult to control my own thoughts. | (0) | (1) | (2) | (3) | (4) |
| 7. I collect things I don't need. | (0) | (1) | (2) | (3) | (4) |
| 8. I repeatedly check doors, windows, drawers, etc. | (0) | (1) | (2) | (3) | (4) |
| 9. I get upset if others change the way I have arranged things. | (0) | (1) | (2) | (3) | (4) |
| 10. I feel I have to repeat certain numbers. | (0) | (1) | (2) | (3) | (4) |
| 11. I sometimes have to wash or clean myself simply because I feel contaminated. | (0) | (1) | (2) | (3) | (4) |
| 12. I am upset by unpleasant thoughts that come into my mind against my will. | (0) | (1) | (2) | (3) | (4) |
| 13. I avoid throwing things away because I am afraid I might need them later. | (0) | (1) | (2) | (3) | (4) |
| 14. I repeatedly check gas and water taps and light switches after turning them off. | (0) | (1) | (2) | (3) | (4) |
| 15. I need things to be arranged in a particular order. | (0) | (1) | (2) | (3) | (4) |
| 16. I feel that there are good and bad numbers. | (0) | (1) | (2) | (3) | (4) |
| 17. I wash my hands more often and longer than necessary. | (0) | (1) | (2) | (3) | (4) |
| 18. I frequently get nasty thoughts and have difficulty in getting rid of them. | (0) | (1) | (2) | (3) | (4) |



PSWQ

ID NUMBER	STAFF/FACULTY ONLY	VISIT NUMBER
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

Directions: A number of statements which people have used to describe themselves are given below. Please read each statement and then fill in the appropriate number to indicate the extent to which the statement applies to you. There are no right or wrong answers. Do not spend too much time on any one statement, but give the answer that generally describes you.

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



BDI

ID NUMBER	STAFF/FACULTY ONLY	VISIT NUMBER
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

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! Fill in the bubble beside the statement you picked. If several statements in the group seem to apply equally well, fill in each one. **Be sure to read all the statements in each group before making your choice.**

- | | |
|--|---|
| <p>1 <input type="radio"/> I do not feel sad.
 <input type="radio"/> I feel sad.
 <input type="radio"/> I am sad all the time and I can't snap out of it.
 <input type="radio"/> I am so sad or unhappy that I can't stand it.</p> <p>2 <input type="radio"/> I am not particularly discouraged about the future.
 <input type="radio"/> I feel discouraged about the future.
 <input type="radio"/> I feel I have nothing to look forward to.
 <input type="radio"/> I feel that the future is hopeless and that things cannot improve.</p> <p>3 <input type="radio"/> I do not feel like a failure.
 <input type="radio"/> I feel that I have failed more than the average person.
 <input type="radio"/> As I look back on my life, all I can see is a lot of failures.
 <input type="radio"/> I feel I am a complete failure as a person.</p> <p>4 <input type="radio"/> I get as much satisfaction out of things as I used to.
 <input type="radio"/> I don't enjoy things the way I used to.
 <input type="radio"/> I don't get real satisfaction out of anything anymore.
 <input type="radio"/> I am dissatisfied or bored with everything.</p> <p>5 <input type="radio"/> I don't feel particularly guilty.
 <input type="radio"/> I feel guilty a good part of the time.
 <input type="radio"/> I feel quite guilty most of the time.
 <input type="radio"/> I feel guilty all of the time.</p> <p>6 <input type="radio"/> I don't feel I am being punished.
 <input type="radio"/> I feel I may be punished.
 <input type="radio"/> I expect to be punished.
 <input type="radio"/> I feel I am being punished.</p> <p>7 <input type="radio"/> I don't feel disappointed in myself.
 <input type="radio"/> I am disappointed in myself.
 <input type="radio"/> I am disgusted with myself.
 <input type="radio"/> I hate myself.</p> <p>8 <input type="radio"/> I don't feel I am any worse than anybody else.
 <input type="radio"/> I am critical of myself for my weaknesses or mistakes.
 <input type="radio"/> I blame myself all the time for my faults.
 <input type="radio"/> I blame myself for everything bad that happens.</p> <p>16 <input type="radio"/> I can sleep as well as usual.
 <input type="radio"/> I don't sleep as well as I used to.</p> | <p>9 <input type="radio"/> I don't have any thoughts of killing myself.
 <input type="radio"/> I have thoughts of killing myself, but I would not carry them out.
 <input type="radio"/> I would like to kill myself.
 <input type="radio"/> I would kill myself if I had the chance.</p> <p>10 <input type="radio"/> I don't cry any more than usual.
 <input type="radio"/> I cry more now than I used to.
 <input type="radio"/> I cry all the time now.
 <input type="radio"/> I used to be able to cry, but now I can't cry even though I want to.</p> <p>11 <input type="radio"/> I am no more irritated now than I ever am.
 <input type="radio"/> I get annoyed or irritated more easily than I used to.
 <input type="radio"/> I feel irritated all the time now.
 <input type="radio"/> I don't get irritated at all by the things that used to irritate me.</p> <p>12 <input type="radio"/> I have not lost interest in other people.
 <input type="radio"/> I am less interested in other people than I used to be.
 <input type="radio"/> I have lost most of my interest in other people.
 <input type="radio"/> I have lost all of my interest in other people.</p> <p>13 <input type="radio"/> I make decisions about as well as I ever could.
 <input type="radio"/> I put off making decisions more than I used to.
 <input type="radio"/> I have greater difficulty in making decisions than before.
 <input type="radio"/> I can't make decisions at all anymore.</p> <p>14 <input type="radio"/> I don't feel I look any worse than I used to.
 <input type="radio"/> I am worried that I am looking old or unattractive.
 <input type="radio"/> I feel that there are permanent changes in my appearance that make me look unattractive.
 <input type="radio"/> I believe that I look ugly.</p> <p>15 <input type="radio"/> I can work about as well as before.
 <input type="radio"/> It takes an extra effort to get started at doing something.
 <input type="radio"/> I have to push myself very hard to do anything.
 <input type="radio"/> I can't do any work at all.</p> |
|--|---|

- ② I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- ③ I wake up several hours earlier than I used to and cannot get back to sleep.

- 17** ① I don't get more tired than usual.
- ① I get tired more easily than I used to.
 - ② I get tired from doing almost anything.
 - ③ I am too tired to do anything.

- 18** ① My appetite is no worse than usual.
- ① My appetite is not as good as it used to be.
 - ② My appetite is much worse now.
 - ③ I have no appetite at all anymore.

- 19** ① I haven't lost much weight, if any, lately.
- ① I have lost more than 5 pounds.
 - ② I have lost more than 10 pounds.
 - ③ I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less

Yes No

- 20** ① I am no more worried about my health than usual.
- ① I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
 - ② I am very worried about physical problems and its hard to think about much else.
 - ③ I am so worried about my physical problems that I cannot think about anything else.

- 21** ① I have not noticed any recent change in my interest in sex.
- ① I am less interested in sex than I used to be.
 - ② I am much less interested in sex now.
 - ③ I have lost interest in sex completely.



SDS

<u>ID NUMBER</u>	<u>STAFF/FACULTY ONLY</u>	<u>VISIT NUMBER</u>
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)

Please fill in a number (in the bubbles corresponding to the scale provided) that best describes your situation **now**:

Work

Because of my problems, my work is impaired:

not at all	mildly	moderately	markedly	Very severely (cannot work)						
0	1	2	3	4	5	6	7	8	9	10
(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(+)

Social life/Leisure activities

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

Because of my problems, my social life is impaired:

not at all	mildly	moderately	markedly	Very severely (cannot work)						
0	1	2	3	4	5	6	7	8	9	10
(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(+)

Family life/Home responsibilities

(e.g., relating to family members, paying bills, managing home, shopping and cleaning)

Because of my problems, my home responsibilities are impaired:

not at all	mildly	moderately	markedly	Very severely (cannot work)						
0	1	2	3	4	5	6	7	8	9	10
(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(+)



Q-LES-Q

<u>ID NUMBER</u>	<u>STAFF/FACULTY ONLY</u>	<u>VISIT NUMBER</u>
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

Taking everything into consideration, during the past week how satisfied have you been with your...

Overall Level of Satisfaction

Very				Very
Poor	Poor	Fair	Good	Good

- | | | | | | |
|--|---|---|---|---|---|
| 1. Physical health?..... | ① | ② | ③ | ④ | ⑤ |
| 2. Mood?..... | ① | ② | ③ | ④ | ⑤ |
| 3. Work?..... | ① | ② | ③ | ④ | ⑤ |
| 4. Household activities?..... | ① | ② | ③ | ④ | ⑤ |
| 5. Social relationships?..... | ① | ② | ③ | ④ | ⑤ |
| 6. Family relationships?..... | ① | ② | ③ | ④ | ⑤ |
| 7. Leisure time activities?..... | ① | ② | ③ | ④ | ⑤ |
| 8. Ability to function in daily life?..... | ① | ② | ③ | ④ | ⑤ |
| 9. Sexual drive, interest, and/or performance?* | ① | ② | ③ | ④ | ⑤ |
| 10. Economic status?..... | ① | ② | ③ | ④ | ⑤ |
| 11. Living/housing situation?* | ① | ② | ③ | ④ | ⑤ |
| 12. Ability to get around physically without
feeling dizzy or unsteady or falling?* | ① | ② | ③ | ④ | ⑤ |
| 13. Your vision in terms of ability to do work or hobbies?* | ① | ② | ③ | ④ | ⑤ |
| 14. Overall sense of well being?..... | ① | ② | ③ | ④ | ⑤ |
| 15. Medication?..... | ① | ② | ③ | ④ | ⑤ |

(If not taking any, fill-in here ○ and leave item blank.)

Overall Level of Satisfaction

Very				Very
Poor	Poor	Fair	Good	Good

16. How would you rate your overall life satisfaction
and contentment during the past week?..... ① ② ③ ④ ⑤

* If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with the lack of satisfaction.



ISH

ID NUMBER	STAFF/FACULTY ONLY	VISIT NUMBER
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
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_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		
_____ (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)		

Directions: For each question, fill in the appropriate number to indicate the degree to which you feel the statement is true of you, based on how you have been feeling in *last two weeks*, including today.

0 <i>Not at all</i> characteristic or true of me	1 <i>Slightly</i> characteristic or true of me	2 <i>Moderately</i> characteristic or true of me	3 <i>Very characteristic</i> or true of me	4 <i>Extremely</i> characteristic or true of me
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- | | | | | | |
|--|-----|-----|-----|-----|-----|
| 1. I sometimes feel that people are laughing at me behind my back | (0) | (1) | (2) | (3) | (4) |
| 2. At times I feel that people are talking about me | (0) | (1) | (2) | (3) | (4) |
| 3. I am sure that I am being talked about | (0) | (1) | (2) | (3) | (4) |
| 4. I am often bothered by the feeling that people are watching me | (0) | (1) | (2) | (3) | (4) |
| 5. I am sometimes eaten up with jealousy | (0) | (1) | (2) | (3) | (4) |
| 6. I sometimes wonder why I feel so bitter about things | (0) | (1) | (2) | (3) | (4) |
| 7. People sometimes say insulting things about me | (0) | (1) | (2) | (3) | (4) |
| 8. I often feel that people have it in for me | (0) | (1) | (2) | (3) | (4) |
| 9. I sometimes feel that no one understands me | (0) | (1) | (2) | (3) | (4) |
| 10. People I am with have a strong influence on my moods | (0) | (1) | (2) | (3) | (4) |
| 11. I often get involved in things I later wish I could get out of | (0) | (1) | (2) | (3) | (4) |
| 12. I tend to be envious of other people's good fortune | (0) | (1) | (2) | (3) | (4) |
| 13. I think it is safer to trust nobody | (0) | (1) | (2) | (3) | (4) |
| 14. I feel I have to be on guard, even with my friends | (0) | (1) | (2) | (3) | (4) |
| 15. I doubt the honesty of people who are more friendly than I would expect them to be | (0) | (1) | (2) | (3) | (4) |
| 16. I get suspicious of over-friendly strangers | (0) | (1) | (2) | (3) | (4) |
| 17. I have heard voices that no one else could hear | (0) | (1) | (2) | (3) | (4) |
| 18. I have seen things that no one else could see | (0) | (1) | (2) | (3) | (4) |
| 19. I have had thoughts or beliefs that no one else has had | (0) | (1) | (2) | (3) | (4) |