Intake Questionnaire

This questionnaire will help your therapist understand your situation. If you feel uncomfortable answering any of the questions, you may leave them blank and discuss them when you meet with your therapist.

Name: _____ **Date:** _____

Home Address:

_____

Street Address City State Zip Code

Phone: Home _____ Cell _____

Email: _____ (*optional*)

Please check preferred method of contact: Home_____ Cell_____ E-mail_____

Local Emergency Contact: Name: _____Phone: _____

Relationship: _____

Referral Source: How did you come to seek services at the Oakland Cognitive Behavior Therapy Center? (Check all that apply)

_____ Internet

_____ Health professional: Name _____

_____ Other (please specify)_____

Reimbursement: If you would like to receive a monthly statement that you can forward to your insurance company to request reimbursement, please provide the e-mail address you would like us to use: _____

Personal Information

1. Age: _____ 2. Date of birth: _____ 3. Sexual Orientation: _____

4. Gender: How do you identify? _____ What are your pronouns?_____

5. Race/Ethnicity (check all that apply):

White _____ Black/African-American _____ Hispanic/Latino _____ South Asian _____

Middle Eastern _____ East Asian _____ Southeast Asian _____ American Indian/ Alaska Native _____

Pacific Islander _____ Other: _____

6. Current Religious Practices: _____

7. Marital status (check all that apply):

Single, never married ____ Cohabiting ____ Married ____ Widowed ____ Divorced ____ Separated ____

8. Please describe your current romantic/sexual relationships: _____

_____

_____

9. If you are divorced, when did you divorce? _____

10. If you are widowed, when and how did your spouse die? _____

11. If applicable, please list names and ages of your children:

Name	Gender	Age	Occupation

12. Number of persons living in your home and your relationships with them

_____

Family/Social History

1. Mother

Biological parent? Yes _____ No _____ Her occupation _____

Where was she born? _____

If living, age and health status _____

If deceased, year and cause of death _____

2. Father

Biological parent? Yes _____ No _____ His occupation _____

Where was he born? _____

If living, age and health status _____

If deceased, year and cause of death _____

3. Did your parents marry? Yes _____ No_____

4. Did your parents separate or divorce? Yes _____ No_____ If yes, when? _____

5. With whom did you primarily live while growing up?

Both Parents _____ Mother _____ Father _____ Other (please specify)

_____

6. Siblings

Name	Gender	Age	Occupation	Biological?
				Y / N
				Y / N
				Y / N

7. Where were you born? _____ 8. Where did you grow up? _____

9. Is English your first language? Yes _____ No_____ If no, please specify first language _____

10. If no longer living with your parents, at what age did you move out of your parents' home? _____

11. **Before the age of 16**, to what degree did you experience the following?

	None	Slight	Mild	Moderate	Severe
A chaotic home environment (e.g., frequent fighting, minimal structure, etc.)	0	1	2	3	4
Emotional reactions from your primary caregiver(s) that did not match the severity of what happened (e.g., extreme anger to a small mistake or minimal reaction to an abusive or harsh situation)	0	1	2	3	4
Emotional neglect, meaning your problems and experiences were ignored, and you felt that there was no attention or support from your primary caregiver	0	1	2	3	4
Psychological abuse at home (yelled at, falsely punished, subordinated to your siblings, or blackmailed)	0	1	2	3	4
Physical abuse (hit, kicked, beaten up or other types of physical abuse)	0	1	2	3	4
You were bullied, socially ostracized or had difficulties making friends	0	1	2	3	4
You were disciplined or reprimanded by teachers, including sent home, or suspended from school, etc.	0	1	2	3	4
You missed a lot of school	0	1	2	3	4
Financial hardship or strain	0	1	2	3	4

Any other details about your childhood or adolescence you'd like to share:

_____

Education and Employment History

1. Are you going to school now? Yes _____ No_____ Full-time_____ Part-time _____

If yes, where are you going to school? _____

2. Number of years of education completed _____ (*Please count 1st grade as the 1st year, so if you completed 4 years of high school that is 12 years, completed 4 years of college is 16, etc.)*

3. Where did you earn your highest degree? _____

4. Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations)?

Yes _____ No_____ If yes, give details: _____

5. Are you working now? (circle one): Yes _____ No_____

If Yes, many hours per week do you work? _____ Your occupation: _____

If No, what was the last job you held: _____

6. Are you receiving or have you applied for medical leave or disability benefits? Yes _____ No_____

7. Have you ever received medical or disability benefits? Yes _____ No_____

If yes, give details: _____

Current Problems and Treatment History

1. Please describe briefly the problem(s) that brought you in to see a therapist.

_____

_____

_____

a. When did you start having these problems? _____

b. Have you ever had problems like this before? Yes _____ No_____

c. If yes, when? _____

2. Are you currently seeing another mental health professional? Yes _____ No_____ If yes, indicate:

Provider's name _____ Date treatment began_____

3. Have you previously been in psychotherapy or counseling, including individual, group, marital or family therapy?

Yes _____ No_____ If yes, please provide the following information:

Date(s) of treatment	Problem for which treatment was sought	Did you find it helpful?	If yes, in what way was it helpful?	If not, in what way was it unsatisfactory?
		Y / N		
		Y / N		

4. Have you ever made a suicide attempt? No ___ Yes____ If Yes, please give date(s) _____

5. Have you ever purposely harmed yourself (cutting, burning, or other)? No ___ Yes___ If Yes, please indicate when this happened most recently _____

6. Have you ever been hospitalized in an inpatient or partial hospitalization program for mental or emotional difficulties or for drug or alcohol abuse? Yes _____ No_____ If Yes, please complete the following chart.

When were you hospitalized?	For how long?	Reasons for hospitalization or partial hospitalization	Was it voluntary?
			Y / N
			Y / N
			Y / N

7. Do you *currently* take medications or supplements to treat mental/emotional difficulties or substance. If yes, please complete the following chart. (Later in the questionnaire, you will be asked to list medications for other conditions.)

Medication Name	Dosage/ Frequency	When started?	Name of Prescriber	Prescribed for what symptoms?

8. Please list medications you have taken previously to treat mental or emotional difficulties or drug or alcohol abuse:

_____

_____

9. Do any biological relatives have any history of psychiatric, emotional and/or substance use problems?

	Family members
Hyperactivity/attention deficit disorder (ADHD)	
Alcohol or drug abuse	
Panic attacks or phobias or anxiety	
Depression	
Schizophrenia	
Bipolar disorder	
Neurological condition	
Other emotional problems	

Medical History

1. Have you ever had any serious, chronic or recurrent health problems or disabilities?

Yes ___ No___ If Yes, please describe:

	Past / Current
	Past / Current
	Past / Current

2. Have you ever had a head injury? Yes _____ No_____ If Yes, please describe:

_____

3. Are you currently taking medications for any physical health problems? Yes _____ No_____

If Yes, please complete the following chart.

Medication Name	When Started?	Prescribed for what symptoms?

4. What other health care recommendations are you following or aiming to follow?

_____

_____

5. List dates of any hospitalizations for physical problems:

Date Problem

_____

_____

6. When was your last physical examination by a physician? _____What was the outcome? _____

7. Do you exercise? Yes _____ No_____

If yes: how many times per week? _____ how many minutes on average? _____ mins.

8. Height:_____ Weight: _____

Other Background

1. Have you ever been involved in a lawsuit? Yes _____ No_____

If yes, please describe the circumstances and give dates:

_____

2. Have you ever been arrested? Yes _____ No_____

If yes, please describe the circumstances and give dates:

_____

3. Do you have a history of violent or aggressive behavior? Yes ___ No ____ If Yes, please explain:

_____

_____

4. Have you experienced any particular sources of stress in the last year? Yes _____ No_____

If Yes, please explain:

_____

_____

5. Are there any other health care professionals (e.g. physicians, psychotherapists) who have information that might help in your treatment? Yes ___ No___

6. Is there any other information that would be helpful to discuss in the consultation appointment?

_____

_____

Name: _____ Date: _____

Diagnostic Screening Tool

Section I: Mood

During the past **MONTH**, how much have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
1. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
2. Feeling so good, excited, or hyper that other people thought you were not your normal self or you got into trouble?	0	1	2	3	4
3. Sleeping less than usual, but still had a lot of energy?	0	1	2	3	4
4. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4

At any time in your life, how much have you ever been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
5. Little interest or pleasure in doing things	0	1	2	3	4
6. Feeling down, depressed, or hopeless	0	1	2	3	4
7. Feeling more irritated, grouchy, or angry than usual	0	1	2	3	4
8. Sleeping less than usual, but still have a lot of energy	0	1	2	3	4
9. Starting lots more projects than usual or doing more risky things than usual	0	1	2	3	4
10. Thoughts of actually hurting yourself	0	1	2	3	4

Section II: Sleep

During the past **MONTH**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
11. Persistent difficulty falling asleep or staying asleep?	0	1	2	3	4
12. Daytime problems related to trouble	0	1	2	3	4

sleeping, such as fatigue, increased irritability, or trouble concentrating?					
13. Worry or distress about your sleep?	0	1	2	3	4

How many hours of sleep do you get in an average night? _____

Section III: Anxiety

During the past **MONTH**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
14. Having a panic attack that came out of the blue (a sudden, unpredicted onset of intense fear or discomfort accompanied by intense bodily sensations and an intense urge to flee that reached its peak intensity within several minutes)?	0	1	2	3	4
15. Persistent concern about having a panic attack, worry about the implications or consequences of the attack, or a significant change in behavior related to the attacks?	0	1	2	3	4
16. Avoiding or feeling afraid of being in places or situations in which you may experience panic symptoms (e.g., being in crowds, standing in line, being in open spaces, or traveling on buses or trains or airplanes)?	0	1	2	3	4
17. Avoiding or feeling very fearful in social or performance situations (e.g., public speaking, parties, dating) because you think you will humiliate or embarrass yourself or be judged negatively by others?	0	1	2	3	4
18. Avoiding or feeling very fearful in relation to other things or situations such as flying, seeing blood, getting an injection, heights, small enclosed places, or certain kinds of animals or insects? If so, what do you fear/avoid: _____	0	1	2	3	4

19. Worrying excessively, more days than not, about a several events/activities and finding it difficult to control the worry?	0	1	2	3	4
20. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
21. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4

Have any of the following events ever happened to you?	**Yes**	**No**	**If Yes, at what age?**
Experiencing or witnessing an event that involved actual or threatened death or serious injury to yourself or another person			
You were sexually abused, meaning touched or having to touch someone in a sexual way against your will			
Sexual assault or rape			

If you checked any of the above, has that experience led to any of the following? (please check if so)

_____ Repeated involuntary memories, dreams, or flashbacks of the traumatic event

_____ Avoiding people, places, activities, objects, or situations that remind you of what happened

Section III: Substance Use

Please specify quantity/frequency (e.g., 2 glasses of wine per day) of most frequent and current use for each of the following:

Substance	**Most frequent use**	**Current use**
	Quantity/Frequency	**Quantity/Frequency**
Caffeine (e.g., coffee, black tea, dark chocolate)		
Tobacco (e.g., cigarettes, cigars, chewing tobacco)		
Alcohol (e.g., beer, wine, hard liquor)		
Sedatives (e.g., Valium, Xanax, Klonopin, Ambien, Sonata, Lunesta, barbiturates, Ativan, Halcion, Restoril)		
Cannabis (e.g., marijuana, hashish, THC, pot, grass, weed)		

Stimulants (e.g., amphetamine, speed, crystal meth, dexadrine, Ritalin, ice)		
Opioids (e.g., heroin, morphine, opium, Methadone, Darvon, codeine, Percodan, Demerol, Dilaudid, oxycontin, oxycodone, hydrocodone, vicodin)		
Cocaine (e.g., crack, speedball)		
Hallucinogens (e.g., LSD, mescaline, peyote, psilocybin, STP, mushrooms, Ecstasy, MDMA)		
PCP (e.g., angel dust, Special K)		
Other (e.g., steroids, nonprescription sleep or diet pills, cough syrup)		

	Yes	No
Have you ever felt you ought to cut down on your drinking or substance use?		
Have people annoyed you by criticizing your drinking or substance use?		
Have you ever felt bad or guilty about your drinking or substance use?		
Have you ever had a drink or used substances first thing in the morning to steady your nerves or to get rid of a hangover?		

Section IV: Additional History

At any time in your life, how much (or how often) have you ever been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
1. Feeling preoccupied with a perceived defect in your appearance (e.g., your height, the shape of your nose, hair loss, your complexion)	0	1	2	3	4
2. Dissatisfaction with my weight	0	1	2	3	4
3. Weighing much less than other people thought you ought to weigh and worrying about becoming fat	0	1	2	3	4
4. Eating large amounts of food and feeling you cannot control how much you are eating	0	1	2	3	4
5. Restricting what you eat to prevent weight gain	0	1	2	3	4
6. Making yourself vomit, use laxatives,	0	1	2	3	4

or exercise a lot to prevent weight gain					
7. Persistent difficulties with paying attention, being easily distracted, losing things, or organizing tasks or activities	0	1	2	3	4
8. Feeling restless when you're sitting still, interrupting others, blurting out things you wish you could take back, difficulty doing leisure activities quietly, or acting without thinking	0	1	2	3	4
9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)	0	1	2	3	4
10. Feeling that your illnesses are not being taken seriously enough	0	1	2	3	4
11. Hearing things other people couldn't hear, such as voices even when no one was around	0	1	2	3	4
12. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking	0	1	2	3	4
13. Recurrently pulling out your hair or picking at your skin to the degree that you experience noticeable hair loss or bleeding or disfigurement from skin picking	0	1	2	3	4
14. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)	0	1	2	3	4
15. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories	0	1	2	3	4
16. Not knowing who you really are or what you want out of life	0	1	2	3	4
17. Not feeling close to other people or enjoying your relationships with them	0	1	2	3	4
18. Difficulties communicating your thoughts and feelings to other people	0	1	2	3	4

What psychiatric diagnoses, if any, have you ever received?

_____

DASS21

Name: *Date:*

Please read each statement and circle a number 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 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 of 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 (eg, in the hands)	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
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 I wasn't worth 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
22	I thought about death or suicide	0	1	2	3
23	I wanted to kill myself	0	1	2	3

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
☐	☐	☐	☐

(OBQ-44)

This inventory lists different attitudes or beliefs that people sometimes hold. Read each statement carefully and decide how much you agree or disagree with it.

For each of the statements, choose the number matching the answer that *best describes how you think.* Because people are different, there are no right or wrong answers.

To decide whether a given statement is typical of your way of looking at things, simply keep in mind what you are like *most of the time.*

Use the following scale:

1	2	3	4	5	6	7
disagree very much	disagree moderately	disagree a little	neither agree nor disagree	agree a little	agree moderately	agree very much

In making your ratings, try to avoid using the middle point of the scale (4), but rather indicate whether you usually disagree or agree with the statements about your own beliefs and attitudes.

6. I often think things around me are unsafe.	1	2	3	4	5	6	7
10. If I'm not absolutely sure of something, I'm bound to make a mistake	1	2	3	4	5	6	7
13. Things should be perfect according to my own standards.	1	2	3	4	5	6	7
19. In order to be a worthwhile person, I must be perfect at everything I do.	1	2	3	4	5	6	7
20. When I see any opportunity to do so, I must act to prevent bad things from happening.	1	2	3	4	5	6	7
23. Even if harm is very unlikely, I should try to prevent it at any cost.	1	2	3	4	5	6	7
24. For me, having bad urges is as bad as actually carrying them out.	1	2	3	4	5	6	7
27. If I don't act when I foresee danger, then I am to blame for any consequences.	1	2	3	4	5	6	7
28. If I can't do something perfectly, I shouldn't do it at all.	1	2	3	4	5	6	7
31. I must work to my full potential at all times.	1	2	3	4	5	6	7
32. It is essential for me to consider all possible outcomes of a situation.	1	2	3	4	5	6	7
33. Even minor mistakes mean a job is not complete.	1	2	3	4	5	6	7

1	2	3	4	5	6	7
disagree very much	disagree moderately	disagree a little	neither agree nor disagree	agree a little	agree moderately	agree very much

34. If I have aggressive thoughts or impulses about my loved ones, this means I may secretly want to hurt them.	1	2	3	4	5	6	7
35. I must be certain of my decisions.	1	2	3	4	5	6	7
38. In all kinds of daily situations, failing to prevent harm is just as bad as deliberately causing harm.	1	2	3	4	5	6	7
39. Avoiding serious problems (for example, illness or accidents) requires constant effort on my part.	1	2	3	4	5	6	7
41. For me, not preventing harm is as bad as causing harm.	1	2	3	4	5	6	7
42. I should be upset if I make a mistake.	1	2	3	4	5	6	7
43. I should make sure others are protected from any negative consequences of my decisions or actions	1	2	3	4	5	6	7
45. For me, things are not right if they are not perfect.	1	2	3	4	5	6	7
46. Having nasty thoughts means I am a terrible person.	1	2	3	4	5	6	7
50. If I do not take extra precautions, I am more likely than others to have or cause a serious disaster.	1	2	3	4	5	6	7
53. In order to feel safe, I have to be as prepared as possible for anything that could go wrong.	1	2	3	4	5	6	7
55. I should not have bizarre or disgusting thoughts.	1	2	3	4	5	6	7
56. For me, making a mistake is as bad as failing completely.	1	2	3	4	5	6	7
57. It is essential for everything to be clear cut, even in minor matters.	1	2	3	4	5	6	7
58. Having a blasphemous thought is as sinful as committing a sacrilegious act.	1	2	3	4	5	6	7
59. I should be able to rid my mind of unwanted thoughts.	1	2	3	4	5	6	7
61. I am more likely than other people to accidentally cause harm to myself or to others.	1	2	3	4	5	6	7

1	2	3	4	5	6	7
disagree very much	disagree moderately	disagree a little	neither agree nor disagree	agree a little	agree moderately	agree very much

64. Having bad thoughts means I am weird or abnormal.	1	2	3	4	5	6	7
65. I must be the best at things that are important to me.	1	2	3	4	5	6	7
66. Having an unwanted sexual thought or image means I really want to do it.	1	2	3	4	5	6	7
67. If my actions could have even a small effect on a potential misfortune, I am responsible for the outcome.	1	2	3	4	5	6	7
68. Even when I am careful, I often think that bad things will happen.	1	2	3	4	5	6	7
69. Having intrusive thoughts means I'm out of control.	1	2	3	4	5	6	7
72. Harmful events will happen unless I am very careful.	1	2	3	4	5	6	7
74. I must keep working at something until it's done exactly right.	1	2	3	4	5	6	7
76. Having violent thoughts means I will lose control and become violent.	1	2	3	4	5	6	7
77. To me, failing to prevent a disaster is as bad as causing it.	1	2	3	4	5	6	7
78. If I don't do a job perfectly, people won't respect me.	1	2	3	4	5	6	7
79. Even ordinary experiences in my life are full of risk.	1	2	3	4	5	6	7
83. Having a bad thought is morally no different than doing a bad deed.	1	2	3	4	5	6	7
84. No matter what I do, it won't be good enough.	1	2	3	4	5	6	7
86. If I don't control my thoughts, I'll be punished.	1	2	3	4	5	6	7

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Perseverative Thinking Questionnaire Date: _____

Instruction: In this questionnaire, you will be asked to describe how you *typically* think about negative experiences or problems. Please read the following statements and rate the extent to which they apply to you when you think about negative experiences or problems.

	never	rarely	sometimes	often	almost always
1. The same thoughts keep going through my mind again and again.	0	1	2	3	4
2. Thoughts intrude into my mind.	0	1	2	3	4
3. I can't stop dwelling on them.	0	1	2	3	4
4. I think about many problems without solving any of them.	0	1	2	3	4
5. I can't do anything else while thinking about my problems.	0	1	2	3	4
6. My thoughts repeat themselves.	0	1	2	3	4
7. Thoughts come to my mind without me wanting them to.	0	1	2	3	4
8. I get stuck on certain issues and can't move on.	0	1	2	3	4
9. I keep asking myself questions without finding an answer.	0	1	2	3	4
10. My thoughts prevent me from focusing on other things.	0	1	2	3	4
11. I keep thinking about the same issue all the time.	0	1	2	3	4
12. Thoughts just pop into my mind.	0	1	2	3	4
13. I feel driven to continue dwelling on the same issue.	0	1	2	3	4
14. My thoughts are not much help to me.	0	1	2	3	4
15. My thoughts take up all my attention.	0	1	2	3	4

MOS Social Support Survey

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? Circle one number on each line.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Emotional/informational support					
Someone you can count on to listen to you when you need to talk	1	2	3	4	5
Someone to give you information to help you understand a situation	1	2	3	4	5
Someone to give you good advice about a crisis	1	2	3	4	5
Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
Some whose advice you really want	1	2	3	4	5
Someone to share your most private worries and fears with	1	2	3	4	5
Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
Someone who understands your problems	1	2	3	4	5
Tangible support					
Someone to help you if you were confined to bed	1	2	3	4	5
Someone to take you to the doctor if you needed it	1	2	3	4	5
Someone to prepare your meals if you were unable to do it yourself	1	2	3	4	5
Someone to help with daily chores if you were sick	1	2	3	4	5
Affectionate support					
Someone who shows you love and affection	1	2	3	4	5
Someone to love and make you feel wanted	1	2	3	4	5
Someone who hugs you	1	2	3	4	5

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Positive social interaction					
Someone to have a good time with	1	2	3	4	5
Someone to get together with for relaxation	1	2	3	4	5
Someone to do something enjoyable with	1	2	3	4	5
Additional item					
Someone to do things with to help you get your mind off things	1	2	3	4	5

Participant ID: Date:

Difficulties in Emotion Regulation Scale (DERS)

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item.

1	2	3	4	5
almost never (0-10%)	sometimes (11-35%)	about half the time (36-65%)	most of the time (66-90%)	almost always (91-100%)

_____ 1) I am clear about my feelings.

_____ 2) I pay attention to how I feel.

_____ 3) I experience my emotions as overwhelming and out of control.

_____ 4) I have no idea how I am feeling.

_____ 5) I have difficulty making sense out of my feelings.

_____ 6) I am attentive to my feelings.

_____ 7) I know exactly how I am feeling.

_____ 8) I care about what I am feeling.

_____ 9) I am confused about how I feel.

_____ 10) When I'm upset, I acknowledge my emotions.

_____ 11) When I'm upset, I become angry with myself for feeling that way.

_____ 12) When I'm upset, I become embarrassed for feeling that way.

_____ 13) When I'm upset, I have difficulty getting work done.

_____ 14) When I'm upset, I become out of control.

_____ 15) When I'm upset, I believe that I will remain that way for a long time.

_____ 16) When I'm upset, I believe that I will end up feeling very depressed.

_____ 17) When I'm upset, I believe that my feelings are valid and important.

_____ 18) When I'm upset, I have difficulty focusing on other things.

_____ 19) When I'm upset, I feel out of control.

_____ 20) When I'm upset, I can still get things done.

_____ 21) When I'm upset, I feel ashamed at myself for feeling that way.

Participant ID: Date:

1	2	3	4	5
almost never (0-10%)	sometimes (11-35%)	about half the time (36-65%)	most of the time (66-90%)	almost always (91-100%)

_____ 22) When I'm upset, I know that I can find a way to eventually feel better.

_____ 23) When I'm upset, I feel like I am weak.

_____ 24) When I'm upset, I feel like I can remain in control of my behaviors.

_____ 25) When I'm upset, I feel guilty for feeling that way.

_____ 26) When I'm upset, I have difficulty concentrating.

_____ 27) When I'm upset, I have difficulty controlling my behaviors.

_____ 28) When I'm upset, I believe there is nothing I can do to make myself feel better.

_____ 29) When I'm upset, I become irritated at myself for feeling that way.

_____ 30) When I'm upset, I start to feel very bad about myself.

_____ 31) When I'm upset, I believe that wallowing in it is all I can do.

_____ 32) When I'm upset, I lose control over my behavior.

_____ 33) When I'm upset, I have difficulty thinking about anything else.

_____ 34) When I'm upset I take time to figure out what I'm really feeling.

_____ 35) When I'm upset, it takes me a long time to feel better.

_____ 36) When I'm upset, my emotions feel overwhelming.

Work and Social Adjustment Scale

Date _____

Rate each of the following questions on a 0 to 8 scale: 0 indicates no impairment at all and 8 indicates very severe impairment.

1. Because of my [disorder], my ability to work is impaired. 0 means not at all impaired and 8 means very severely impaired to the point I can't work.
2. Because of my [disorder], my home management (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired. 0 means not at all impaired and 8 means very severely impaired.
3. Because of my [disorder], my social leisure activities (with other people, such as parties, bars, clubs, outings, visits, dating, home entertainment) are impaired. 0 means not at all impaired and 8 means very severely impaired.
4. Because of my [disorder], my private leisure activities (done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired. 0 means not at all impaired and 8 means very severely impaired.
5. Because of my [disorder], my ability to form and maintain close relationships with others, including those I live with, is impaired. 0 means not at all impaired and 8 means very severely impaired.