San Francisco Group for Evidence-Based Psychotherapy

Adult Intake Questionnaire

Your Name: _____

Address: _____

Phone: (Home) _____ (Work) _____

(Cell)_____ (Other, please specify) _____

Email: _____

Emergency Contact: (Name) _____

(Phone) _____ (Relationship) _____

Referred by _____ Phone_____

REIMBURSEMENT The monthly statement you will receive can be forwarded to your insurance company to request reimbursement. If you would like your social security number included on this statement, please include it here:

_____

Please mail the monthly statement to the following address (circle one): Home Business Other

_____

_____

Age: _____ Gender: _____ Date of birth: _____

Ethnicity (circle one): Caucasian African American Hispanic Asian

Other: _____

Religious background: Protestant Catholic Jewish Muslim Buddhist No affiliation

(circle one) Other: _____

Marital status: Single, never married Married Separated Divorced

(circle one) Widowed Cohabiting

If you divorced, when did you divorce your previous partner? _____

How long were you married? _____

If you are widowed, when did your spouse die? _____

Education: (number of years completed) _____

Occupation: _____

Are you working now? No Yes (circle one) If yes, circle one: Full-time Part-time

Are you going to school now? No Yes (circle one) If yes, circle one: Full-time Part-time

Names of persons living in your home and your relationship to them:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Spouse/partner's occupation, if applicable:_____

Please provide the following information about your family:

Mother Name: _____

If deceased, year and cause of death: _____

If living, age and health status: _____

If living, where does she live now? _____

Her occupation (past and/or present): _____

Father Name: _____

If deceased, year and cause of death:_____

If living, age and health status: _____

If living, where does he live now? _____

His occupation (past and/or present): _____

Siblings:

Name	Age	Occupation	Where does s/he live?
_____			
_____			
_____			
_____			

Where did you grow up?_____

Were your parents ever separated? Yes No (circle one) If yes, when?_____

Did your parents get divorced? Yes No (circle one) If yes, when? _____

Did they remarry? Yes No (circle one) If yes, when? _____

At what age did you move out of your parents' home? _____

What is the highest degree you earned in school? _____ When? _____

Did you ever leave a school you were enrolled in prior to completion? Yes No (circle one)

If yes, give details: _____

Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations, etc.)? Yes No (circle one) If yes, give details: _____

_____

If you were physically disciplined as a child, were you ever injured as a result? Yes No (circle one)

Did your parent or a person taking care of you ever purposefully injure you in other circumstances (that is, when you were not being disciplined)? Yes No (circle one)

Did you ever have sexual contact with someone else that you did not want? Yes No (circle one)

Have you experienced or witnessed any traumas (events that felt life-threatening)? Yes No (circle one)

Have you experienced physical or sexual abuse or assaults? Yes No (circle one)

Please provide some general information on your work history:

Type of job held How long?

_____

_____

_____

If you have a partner or spouse, how long have you been together? _____

Please list names and ages of your children, if applicable:

Name	Age	Biological?	Name	Age	Biological?
		Y/N			Y/N
		Y/N			Y/N

Please describe, briefly, the problem(s) that bring you in to see me.

What are the symptoms, how intense are they, and how often do they occur?

_____

_____

_____

_____

Have there ever been problems like this before? Yes No (circle one)

If yes, when? _____

Are you presently seeing another therapist? Yes No (circle one)

If yes, please give us the following information:

Therapist's name: _____ Date treatment began: _____

Therapist's address:_____

Therapist's phone number: _____

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

Yes No (circle one)

If yes, please give us the following information:

Therapist's name(s), phone number(s) and address(es): _____

_____

_____

Date(s) of treatment : _____

Problem for which treatment was sought:_____

If you have been in psychotherapy before, was it helpful? Yes No (circle one)

If yes, in what way was it helpful? _____

If not, in what way was it unsatisfactory? _____

Has hospitalization or partial hospitalization for mental or emotional difficulties ever been recommended for you?

Yes No (circle one) If yes, when and why? _____

Have you ever been hospitalized or participated in a partial hospitalization program for mental or emotional difficulties? Yes No (circle one) If yes, when and why? _____

Was the hospitalization voluntary? Yes No (circle one)

Has a physician/psychiatrist ever recommended that you take medication for mental or emotional difficulties (e.g. Prozac, Xanax, etc.)? Yes No (circle one)

If yes, what medications were recommended, when and for what symptoms?

_____

Have you ever <u>taken</u> medications for mental or emotional difficulties prescribed by a physician/psychiatrist?

Yes No (circle one)

If yes, what medications were prescribed, when and for what symptoms?

_____

Are you currently using any prescribed medications? Yes No (circle one)

Please indicate what medications you are taking:

Medication Dosage When started Prescriber

_____

_____

_____

_____

_____

Have you ever used any drugs or medications other than as prescribed? (This includes prescription medications, marijuana, PCP, LSD, amphetamines, barbiturates, cocaine, opiates, prescribed drugs (e.g. valium), Ecstasy and others)

Yes No (circle one) Are you currently using? Yes No (circle one)

If yes, please check which ones and fill out the requested information:

Type Frequency/amount Duration How taken

_____

_____

_____

If you have used any substances listed above, do you feel they have caused any problems in your work, school or relationships?

Yes No (circle one)

If yes, please explain: _____

_____

Do you drink alcohol? Yes No (circle one)

If yes, please answer the following questions:

Have you ever felt you ought to cut down on your drinking?

Yes No (circle one)

Have people annoyed you by criticizing your drinking?

Yes No (circle one)

Have you ever felt bad or guilty about your drinking?

Yes No (circle one)

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

Yes No (circle one)

How much alcohol do you drink? _____drinks per _____

Do you feel your drinking has caused any problems in your work, school or relationships? Yes No (circle one)

If yes, please explain: _____

_____

Has treatment for drug or alcohol abuse ever been recommended to you?

Yes No (circle one)

If yes, please describe the circumstances and give dates.

_____

_____

Have you ever been treated for drug or alcohol abuse?

Yes No (circle one)

If yes, please describe the provider and program, give dates and describe the outcome.

_____

_____

Have you ever had a physical fight with anyone, including your spouse or partner (including throwing things, hitting, shoving, etc.)? Yes No (circle one)

Do you currently have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities? Yes No (circle one)

If yes, please describe: _____

List dates of any hospitalizations you have had for physical problems:

Date Problem

_____

_____

_____

When was your last physical examination by a doctor? _____

What was the outcome? _____

Do any biological relatives have any history of psychiatric or emotional problems? Yes No

If yes, which family members and what types of problems?

_____

_____

Have you ever been involved in a lawsuit?

Yes No (circle one)

If yes, please describe the circumstances and give dates.

_____

_____

Have you ever been arrested for a crime?

Yes No (circle one)

If yes, please describe the circumstances and give dates.

_____

_____

Have you experienced any particular sources of stress in the last year?

Yes No (circle one)

If yes, please explain: _____

Are there any other health care professionals (e.g. physicians, psychotherapists, etc.) whom you feel might have information that would help in your treatment?

Yes No (circle one)

If yes, please give details: _____

_____

_____

_____

Is there any other background information you think would be helpful for me to know?

Yes No (circle one)

If yes, please explain: _____

_____

_____

_____

_____ _____

Signature Date

San Francisco Group *for* Evidence-Based Psychotherapy
Treatment/Evaluation Agreement

This document contains important information about the professional services and business policies of Anya Ho, Ph.D. and the San Francisco Group for Evidence-Based Psychotherapy. Please read it carefully and discuss any questions you have with Dr. Ho.

ASSESSMENT AND TREATMENT: Dr. Ho will provide an assessment of your difficulties and available treatment options. If she recommends and you agree, she will provide a form of evidence-based psychotherapy (cognitive-behavioral therapy or dialectical behavior therapy, most commonly), which has been shown in controlled outcome studies to be effective for a number of problems and disorders. (Dr. Ho will review the outcome data most pertinent to your situation upon request.) However, no guarantees can be made regarding the success of treatment. Treatment can be time-consuming and stressful; it can bring on strong feelings, such as anger, frustration, sadness, or anxiety; and it may result in changes that were not originally intended (such as remaining in a relationship or job you believed you would leave). There is a small risk that your condition will worsen due to treatment. After meeting with you to assess your situation, Dr. Ho will offer, if you would like, an estimate of the number of sessions of treatment she recommends for you. For most patients, this ranges between 5 and 40 sessions. Dr. Ho's estimate of the duration of treatment is only an estimate, and no guarantees can be made as to the length of treatment required.

ALTERNATIVE TREATMENTS: Many options to the treatment that Dr. Ho can provide are available, including other types of individual psychotherapy, group, or family therapy, and, in many cases, medications. Testing and other formal evaluation procedures
can be helpful in some cases, and if Dr. Ho recommends this in your case, she will let you know what her recommendation is and the reasons for it.

You are entitled to ask questions about all aspects of treatment. Dr. Ho will help you secure a consultation with another mental health professional whenever you request it or she recommends it.

TRAINING AND EXPERIENCE: Dr. Ho is a psychologist licensed to practice in California (License # PSY 21704). She graduated from the Ohio State University with a Ph.D. in Clinical Psychology in 2004. She received postdoctoral training at Judge Baker Children's Center, Harvard Medical School and was a research fellow at Boston University's Center for Anxiety and Related Disorders. She teaches and supervises trainees at University of California San Francisco and is an Assistant Clinical Professor there.

THE PATIENT'S ROLE: You are expected to play an active role in your treatment, including working with Dr. Ho to outline treatment goals and completing questionnaires at the beginning of treatment and periodically during treatment to assess progress. You will be asked to complete homework assignments between sessions. If at any point you are unhappy about the progress, process, or outcome of the treatment, please discuss this with Dr. Ho in an attempt to resolve any difficulties that have arisen and to arrive at a treatment plan that better meets your needs.

THE PATIENT'S RIGHTS: A document entitled Patient's Bill of Rights, adapted from a publication by the California Department of Consumer Affairs, is attached to the end of this document. Please read it carefully and raise with Dr. Ho any questions you have about it.

HOURS/AVAILABILITY: Dr. Ho is usually available in the office from 9 a.m. until 6 or 7 p.m. on Mondays, Tuesdays, Wednesdays, and Thursdays. Therapy sessions are usually scheduled as 55-minute sessions weekly, or as your treatment needs dictate and you and Dr. Ho agree. Dr. Ho returns phone calls and emails daily when she is not in session. She does not carry an emergency pager and cannot promise to be reachable during the night or over weekends; however, she will make efforts to be responsive to your needs. In a crisis, you can call 911, contact your primary care physician, the local emergency room, or crisis intervention services. When Dr. Ho is out of town, she will let you know and will give you the name and telephone number of another therapist who will be available if she has concerns that she will not be reachable while away.

CONFIDENTIALITY: The confidentiality of communications between the patient and therapist is important and, in general, is legally protected. Dr. Ho will make every effort to keep the results of all your evaluation and treatment strictly confidential, as is required by law. Information about you will be released by Dr. Ho only with your written permission, with the following exceptions:

- when there is suspected elder, dependent adult, or child abuse or neglect.
- when, in Dr. Ho's judgment, you are in danger of harming yourself or are unable to care for yourself.
- if you communicate to Dr. Ho a serious threat of physical violence against another person (at which point Dr. Ho is required by law to inform both potential victims and legal authorities).
- if Dr. Ho is ordered by a court to release information as part of a legal proceeding, or as otherwise required by law.

In the event that group therapy services are provided, you are expected to keep materials shared in the group confidential. Dr. Ho cannot be held responsible for a breach of confidentiality on the part of group members.

If you elect to seek reimbursement from an insurance company for your treatment, Dr. Ho will provide you with a monthly statement you can submit to your insurance company. Most insurance companies require information about your diagnosis, the type of service provided (e.g., 50-minute individual psychotherapy session), the date of the session, and the fee, and Dr. Ho will include this information on your statement. Dr. Ho will generally send this statement to you directly. If for some reason you and Dr. Ho agree that she will communicate directly with your insurance company, please be aware that when information is sent to an insurance company, Dr. Ho has no control over who sees it. Almost all insurance companies state that they will keep the information confidential, but Dr. Ho cannot assure that they will do so. Some share information with a national medical information data bank for the purposes of determining eligibility for life, disability, health, and other insurance. Before Dr. Ho sends any information to an insurance company, she will talk with you about what she has written and she will obtain your written permission to release the information. You do have a choice about whether to authorize the release of information requested by an insurance company, but if you refuse to consent to releasing it, most insurance programs will not pay for services.
You and Dr. Ho may elect to communicate via e-mail. If you do, it is important to remember that if Dr. Ho is obtaining information only via e-mail, she is making clinical judgments on the basis of limited and imperfect information. She may not receive e-mail in a timely fashion, so if your communication is urgent, it may be best to also try the telephone. If you choose to correspond with Dr. Ho through e-mail, she will make every effort to keep the correspondence confidential, but she cannot guarantee the confidentiality of e-mail communications. If you communicate with Dr. Ho via e-mail, you agree to accept the risk that a breach of confidentiality may occur.

RECORD-KEEPING: Dr. Ho maintains a clinical chart for each patient. Information in the chart includes a description of your condition, your diagnosis, treatment goals, treatment plan and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Dr. Ho also keeps records of any consent, release, assessment, or other forms completed in the course of your treatment. Clinical records are kept in a locked file cabinet and on a computer in Dr. Ho's office. The hard drive that includes the material from your clinical record is stored in a locked file cabinet when Dr. Ho is not in the office.

TAPING OF SESSIONS: It can occasionally be clinically useful to videotape or audiotape therapy sessions, but this will never be done without the knowledge and consent of all parties and an agreement about how the material will be used and kept secure.

CONSULTATION: Dr. Ho may wish to consult with other professionals, especially her colleagues at the San Francisco Group for Evidence-Based Psychotherapy, about treatment planning for your case. The consultation process is meant to benefit you by improving upon your treatment. Your signature below gives Dr. Ho permission to do this, provided that she takes reasonable efforts to protect your identity.

RESEARCH, WRITING, TEACHING: Dr. Ho and others at the San Francisco Group for Evidence-Based Psychotherapy may conduct research, training, and supervision, and write for professional and lay audiences. Your signature below gives Dr. Ho permission to use information about you and your treatment in any of these ways, provided that she takes reasonable efforts to protect your identity.

FEES: Dr. Ho's fee is $200 per 55-minute session. Longer or shorter sessions are generally pro-rated from this fee. If you meet with Dr. Ho on the telephone for a 55-minute session, you will be charged the standard session fee. Of course, there will be no charge for contacts made to schedule appointments, or other brief emails and phone interactions, but if you require substantial contact over email or telephone in between sessions, you may be charged for this time at the above (pro-rated) rate. If you request that Dr. Ho prepare paperwork for you (for example, a treatment summary for another source), she may bill for the time that this requires. She generally will not bill for time spent consulting with other current or previous treatment providers unless under unusual circumstances, as she considers this to be part of your treatment, but she may bill for time spent talking with parties whose counsel is believed to be peripheral to the treatment (for example, attorneys you may retain for purposes of outside litigation and with whom you request that she speak).

IF YOU ARE INVOLVED IN LITIGATION IN WHICH YOUR EMOTIONAL STATE OR PARTICIPATION IN THERAPY MAY BE RELEVANT: Dr. Ho prefers not to be involved in any litigation that you may participate in, even as a witness for emotional damages, because her participation in lawsuits can severely compromise your confidentiality, may inadvertently work against your case, and is not believed to be therapeutic. Should her participation be required either by your side or by the opposing side, you will be responsible for reimbursing her at the forensic rate of $275/hour for all time spent in the legal process, including report-writing, consultation with attorneys, testifying, and travel. This will be true regardless of her exact assigned role within the process, whether it be fact witness, expert witness, percipient expert or treating expert, etc.

PAYMENT: Payment is due at the time of each session unless another arrangement has been made. Dr. Ho will provide you with a monthly statement if you request one.

CANCELLATIONS AND MISSED APPOINTMENTS: If an appointment is missed or cancelled without 48 hours notice, you will be charged for the session. Please be aware that insurance companies will not generally reimburse for a cancelled session. The cancellation policy is not meant to feel punitive, but is enforced out of a desire to be fair and consistent with all clients and to protect Dr. Ho's time, which she generally cannot use to help someone else without adequate notice.

REIMBURSEMENT: You are responsible for collecting reimbursement from your insurance company or other source.

ENDING TREATMENT: You may withdraw from treatment at any time. Dr. Ho recommends that you discuss your plan to terminate treatment with her before taking action, so that she has an opportunity to offer her recommendations and referral options if they are needed.

If you discontinue meeting with Dr. Ho for a period of four weeks or more without warning or without an agreement for "as needed" sessions, she will typically attempt to contact you. If she is unable to reach you, she will assume that you have elected to terminate your treatment and she will close your case. Of course, should you wish to resume your treatment, she will be happy to discuss that option with you at any time.

*****

I have read and understood this agreement and the Patient Bill of Rights and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and consent to participate in evaluation and/or treatment.

Name of patient (please print): _____

Signature of patient: _____Date_____

Patient Bill of Rights

You have the right to:

Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.
Receive respectful treatment that will be helpful to you.
A safe environment, free from sexual, physical, and emotional abuse.
Ask questions about your therapy.
Refuse to answer any question or disclose any information you choose not to reveal.
Request that the therapist inform you of your progress.
Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
Refuse a particular type of treatment or end treatment without obligation or harassment.
Refuse electronic recording (but you may request it if you wish).
Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment.
Report unethical and illegal behavior by a therapist.
Receive a second opinion at any time about your therapy or therapist's methods.
Request the transfer of a copy of your file to any therapist or agency you choose.

Excerpted from "Professional Therapy Never Includes Sex," California Department of Consumer Affairs, 1997.5.24.01

Diagnostic Screening Tool **Initials _____** **Date _____**

Section I: Mood

1. In the last month has there been a period of time lasting at least 2 weeks when you:	**Yes**	**No**
a. Felt depressed or down most of the day nearly every day?		
b. Felt a loss of interest or pleasure in most things you normally enjoy for most of the day nearly every day?		

If you answered "Yes" to "a" or "b," indicate which of the following symptoms you experienced during the time you experienced "a" or "b."

___ Loss of appetite nearly every day
___ Increase in appetite nearly every day
___ Weight loss not due to dieting Amount lost (lbs) _____
___ Weight gain Amount gained (lbs) _____
___ Difficulty concentrating or indecisiveness nearly every day
___ Increase in number of hours slept nearly every day
___ Decrease in number of hours slept nearly every day
___ Feeling fidgety, agitated or restless nearly every day
___ Feeling slowed down, sluggish nearly every day
___ Recurring thoughts of suicide, death, or dying
___ Making a plan for suicide
___ Taking some action toward suicide
___ Fatigue or loss of energy
___ Feelings of worthlessness or excessive guilt nearly every day

	Yes	**No**
2. Prior to last month, did you ever have at least a 2 week period when you felt depressed or experienced a loss of interest or pleasure in most things you normally enjoyed?		
a. Approximately how many times has this happened? _____ b. Approximately how old were you when this happened for the first time? ____		
3. Have you experienced depressed mood most of the day nearly every day for at least 2 years?		
a. Is that happening now or was it in the past? Now ___ In the past___		
4. In the **last month**, has there been a period of time when you were feeling so good, high, excited, "hyper," or irritable that other people thought you were not your normal self or you got into trouble?		
a. How many days did that period of time last? ____		
5. Have you **ever** had a time when you were feeling so good, high, excited, "hyper," or irritable that other people thought you were not your normal self or you were so hyper that you got into trouble?		
6. Have you ever experienced periods in which your mood cycles from periods of low depressed mood and low energy to periods of elated mood with high energy?		

Section II: Substance Use

	Past (Yes/No)	Currently (Yes/No)
1. Have you ever consumed alcohol?		
2. Have you ever used illicit drugs?		
3. Have you ever used medications (prescription or non prescription) other than as directed?		

If no to all, please skip to Section III.
If yes to any of these questions, please specify quantity/frequency (e.g., 2 glasses of wine per day):

Substance	Past		Currently	
	Quantity	Frequency	Quantity	Frequency
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, glue, ethyl chloride, paint, inhalants, nitrous oxide (laughing gas), amyl or butyl nitrate (poppers), nonprescription sleep or diet pills, cough syrup)				

	Yes	No
4. Have you ever felt you ought to cut down on your drinking or substance use?		
5. Have people annoyed you by criticizing your drinking or substance use?		
6. Have you ever felt bad or guilty about your drinking or substance use?		
7. 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?		

8. Please indicate areas where your alcohol or substance use caused problems in the last six months:

Work ____ Legal ____ School _____ Health ____ Relationships ____
Leisure activities____ Financial ____

Section III: Anxiety

	Yes	No
1. Have you ever had a panic attack (a sudden onset of intense fear or discomfort accompanied by intense bodily sensations and an intense urge to flee that reached its peak intensity within 10 minutes)?		
a. If yes, please check symptoms experienced: ___Pounding, racing heart ___Dizzy, lightheaded or faint ___Fear of losing control, going crazy ___Numbness or tingling sensations ___Chest pain or discomfort ___Shortness of breath ___Sweating ___Feelings of unreality or detached ___Nausea/abdominal distress ___Chills or hot flushes ___Fear of dying ___Feelings of choking ___Trembling, shaking		
b. Have you ever had a panic attack that seemed to happen out of the blue (e.g., for no apparent reason)?		
c. Has the panic attack been followed by persistent concern about having additional attacks, worry about the implications or consequences of the attack, or a significant change in behavior related to the attacks?		
2. Do you avoid or feel afraid of being in places or situations in which you may experience panic symptoms (e.g., being in crowds, standing in line, or traveling on buses or trains or airplanes)?		
3. Do you avoid or feel 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?		
4. Are there other things or situations of which you are extremely fearful, such as flying, seeing blood, getting an injection, heights, small enclosed places, or certain kinds of animals or insects?		
If yes, please specify:		
5. In the last six months, have you worried excessively more days than not about a number of future events or activities, and found it difficult to control that worry?		
6. Are you bothered by thoughts, impulses, or images that are extremely uncomfortable (e.g., hurting someone against your will or being contaminated by germs) and that keep coming back even when you try not to have them?		
7. Do you feel driven to continually repeat a behavior (e.g., washing, saying certain phrases in your mind, putting things in a particular order or checking locks, stoves, lights, etc.) and have difficulty resisting the urge to do so?		
8. Have you ever experienced or witnessed an event that involved actual or threatened death or serious injury to yourself or another person?		
If yes, did your response to the event involve intense fear, helplessness or horror?		

	Yes	No
9. Have you ever experienced sexual abuse or assault?		
10. Have you ever had sexual contact with someone that you did not want?		

Section IV: Other

	Yes	No
1. Have you had any unusual experiences such as hearing or seeing things that other people did not seem to hear or see?		
2. Have you ever believed that people were spying on you, out to get you, making plans to hurt you, or following you?		
3. Have you ever believed that people were sending you special messages through the newspaper, radio, TV or internet?		
4. Over the last several years, have you frequently gone to see your physician for physical problems?		
5. Do you frequently worry that you have a serious medical problem even when a doctor tells you otherwise?		
6. Are you preoccupied with a perceived defect in your appearance (e.g., your height, the shape of your nose, amount of hair loss, your complexion)?		
7. Have you ever had a time when you weighed much less than other people thought you ought to weigh?		
If yes, at that time were you very afraid that you could become fat?		
8. Have you often had times when you felt your eating was out of control?		
9. Have you ever made yourself vomit, used laxatives, or exercised a lot to prevent weight gain?		
10. Do you have a history of difficulties with paying attention, being easily distracted, losing things or organizing tasks or activities?		
11. Do you have a history of 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 first without thinking?		
12. Do you experience problems with 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?		

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