



Assistance given?   
(If yes, please tick)

Client ID	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Age	<input type="text"/> <input type="text"/>	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Date form given	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Stage completed <input type="text"/>			
Site/service ID	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	S Screening R Referral A Assessment F First Therapy Session P Pre-therapy (unspecified) D During Therapy L Last Therapy Session X Follow up 1 Y Follow up 2			
Therapist ID	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Episode		<input type="text"/> <input type="text"/>	
Subcodes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

**These questions are about how you have been feeling –  
OVER THE LAST WEEK.**

**Please read each question carefully.**

**Think how often you have felt like that in the last week  
and then put a cross in the box you think fits best.**

**OVER THE LAST WEEK...**

	Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1 I've felt edgy or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2 I haven't felt like talking to anyone	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3 I've felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
4 I've thought of hurting myself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5 There's been someone I felt able to ask for help	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
6 My thoughts and feelings distressed me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7 My problems have felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8 It's been hard to go to sleep or stay asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9 I've felt unhappy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10 I've done all the things I wanted to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0

**THANK YOU FOR ANSWERING THESE QUESTIONS**