Steve Sprinkle, Ph.D.
California Licensed Psychologist #PSY-21849

Name: _____ **Date:** _____

Demographic & Emergency Contact Questions

1. How would you describe your current relationship status? For example, in a committed relationship, single, married, widowed, partnered, polyamorous, separated, divorced, etc.

   _____

2. How would you describe your ethnicity or race? For example, multiracial, Latinx, white, African-American, Chicano, Middle Eastern, Asian-American, etc.

   _____

3. How would you describe your sexuality? For example, gay, heterosexual, pansexual, Lesbian, asexual, straight, bisexual, queer, etc.

   _____

4. How would you describe your gender identity? For example, female, nonbinary, trans man or trans woman, fluid, cis male, etc.

   _____

5. Which pronouns do you use? For example, he/him, they/them, she/her, ze/zir, etc.

   _____

6. In the event I need to contact someone close to you about an emergency, whom should I contact?

   Name: _____

   Relationship to you (mother, spouse, friend, brother, etc.): _____

   Best way to contact: _____

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GAD-7 Anxiety Questionnaire

*Over the **last two weeks**, how often have you been bothered by the following problems?*

a. Feeling nervous, anxious or on edge

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

b. Not being able to stop or control worrying

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

c. Worrying too much about different things

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

d. Trouble relaxing

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

e. Being so restless that it is hard to sit still

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

f. Feeling bad about yourself or that you are a failure or have let yourself or your family down.

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

g. Becoming easily annoyed or irritable

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

h. Feeling afraid as if something awful might happen.

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

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Obsessive Compulsive Inventory-R

The following statements refer to experiences that many people have in their everyday lives. Check the number that best describes how much that experience has distressed or bothered you during the past month.

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

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

Foa, E.B., Huppert, J.D., Leiberg, S., et al. (2002). The obsessive–compulsive inventory: development and validation of a short version. *Psychological Assessment, 14*, 485-496.

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PC-PTSD-5

National Center for PTSD (2015)

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- *a serious accident or fire*
- *a physical or sexual assault or abuse*
- *an earthquake or flood*
- *a war*
- *seeing someone be killed or seriously injured*
- *having a loved one die through homicide or suicide*

Have you ever experienced this kind of event? (circle your answer) ***YES ___*** ***NO ___***

If you answered ***NO*** please stop here; if ***YES*** please answer the questions below.

In the past month, have you…

1. *...had nightmares about the event(s) or thought about the event(s) when you did not want to?* ***YES ___*** ***NO ___***
2. *...tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?* ***YES ___*** ***NO ___***
3. *...been constantly on guard, watchful, or easily startled?* ***YES ___*** ***NO ___***
4. *...felt numb or detached from people, activities, or your surroundings?* ***YES ___*** ***NO ___***
5. *...felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?* ***YES ___*** ***NO ___***

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Insomnia Severity Index

*For each question, note the descriptor that best describes your answer. Please rate the **current severity (i.e., the last two weeks)** of your insomnia problems.*

1. **Rate your difficulty *falling asleep:***

   None ___ Mild ___ Moderate ___ Severe ___ Very Severe ___

2. **Rate your difficulty *staying asleep*:**

   None ___ Mild ___ Moderate ___ Severe ___ Very Severe ___

3. **Rate your problems *waking up too early*:**

   None ___ Mild ___ Moderate ___ Severe ___ Very Severe ___

4. **How *satisfied or dissatisfied* are you with your *current* sleep pattern?**

   Very Satisfied ___ Satisfied ___ Moderately Satisfied ___ Dissatisfied ___ Very Dissatisfied ___

5. **How noticeable to others do you think your sleep problem is in terms of *impairing* your quality of life?**

   Not at all Noticeable ___ A little ___ Somewhat ___ Much ___ Very Much Noticeable ___

6. **How *worried or distressed* are you about your current sleep problem?**

   Not at all Worried ___ A little ___ Somewhat ___ Much ___ Very Much Worried ___

7. **To what extent do you consider your sleep problem to *interfere* with your current daily functioning (e.g., daytime fatigue, mood, ability to manage at work or school or to manage daily chores, concentration, memory, etc.)?**

   Not at all Interfering ___ A little ___ Somewhat ___ Much ___ Very Much Interfering ___

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PHQ-9 Depression Questionnaire

*Over the **last two weeks**, how often have you been bothered by the following problems?*

a. Little interest in or pleasure in doing things

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

b. Feeling down, depressed, or hopeless

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

c. Trouble falling/staying asleep, sleeping too much

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

d. Feeling tired or having little energy

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

e. Poor appetite or overeating.

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

f. Feeling bad about yourself or that you are a failure or have let yourself or your family down

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

g. Trouble concentrating on things, such as reading the newspaper or watching television

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

h. 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

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

i. Thoughts that you would be better off dead or hurting yourself in some way

not at all ___ *several days* ___ *more than half the days* ___ *nearly every day* ___

If you checked off any problem on this questionnaire, how difficult have these problems made it for you to do work, take care of things at home, or get along with people?

not difficult at all ___ *somewhat difficult* ___ *very difficult* ___ *extremely difficult* ___

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Columbia-Suicide Severity Rating Scale

	Past Month?		*Lifetime?*	
	Yes	***No***	***Yes***	***No***
1. Have you ever wished you were dead or wished you could go to sleep and not wake up?				
2. Have you actually had any thoughts of killing yourself?				
If *NO* to question 2, skip to 6; if *YES* answer 3-6				
3. Have you been thinking about how you might kill yourself?				
4. Have you had these thoughts and had some intention of acting on them?				
5. Have you started to work out or worked out details of how to kill yourself? Do you intend to carry out your plan?				

	Yes	**No**
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?		
If *YES*: Was this in the past three months?		

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AUDIT-C Alcohol Questionnaire

by the World Health Organization

1. How often do you have a drink containing alcohol? *(check the most applicable response)*

never ___ *monthly or less* ___ *2-4 times a month* ___ *2-3 times a week* ___ *4+ times a week* ___

If you drink alcohol, please answer these additional questions:

2. How many standard drinks containing alcohol do you have in a typical day?

1 or 2 ___ *3 or 4* ___ *5 or 6* ___ *7 to 9* ___ *10 or more* ___

3. How often do you have six or more drinks on one occasion?

never ___ *less than monthly* ___ *monthly* ___ *weekly* ___ *daily or almost daily* ___

DAST-10 Drug Use Questionnaire

by Harvey A. Skinner, Department of Health Sciences, University of Toronto

The following questions pertain to your use of drugs during ***the past 12 months.*** *In responding to these questions* ***do not include your use of alcohol,*** *but* ***do include your use of cannabis*** *along with* ***any prescription medications*** *you take that are not prescribed to you or that you use in ways that do not adhere to the instructions provided by your prescriber.*

1. **Have you used drugs other than those required for medical reasons?** *YES* ___ *NO* ___

   If *YES,* ***please answer these additional questions:***

2. **Do you abuse more than one drug at a time?** *YES* ___ *NO* ___
3. **Are you always able to stop using drugs when you want to?** *YES* ___ *NO* ___
4. **Have you had *blackouts* or *flashbacks* as a result of your drug use?** *YES* ___ *NO* ___
5. **Do you ever feel bad or guilty about your drug use?** *YES* ___ *NO* ___
6. **Does your partner or spouse or do your parents ever complain about your involvement with drugs?** *YES* ___ *NO* ___
7. **Have you neglected your family because of your use of drugs?** *YES* ___ *NO* ___
8. **Have you engaged in illegal activities in order to obtain drugs?** *YES* ___ *NO* ___
9. **Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?** *YES* ___ *NO* ___
10. **Have you had medical problems because of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?** *YES* ___ *NO* ___