CORE-10

Client ID

Date form completed

D D M M Y Y Y Y

Therapist ID

Service ID

Episode Session

Age

M

F

Stage ....
S Screening
H Referral
V Assessment
F First therapy session
P Pre-therapy (unspecified)
U During therapy
A ALast therapy session
X Follow-up 1
Y Follow-up 2

IMPORTANT - PLEASE READ THIS FIRST

This form has 10 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.

Over the last week...

		Not at all	Only occasionally	Sometimes	Often	Most or all of the time	OFFICE USE ONLY
1	I have felt tense, anxious or nervous	0	1	2	3	4	
2	I have felt I have someone to turn to for support when needed	4	3	2	1	0	
3	I have felt able to cope when things go wrong	4	3	2	1	0	
4	Talking to people has felt too much for me	0	1	2	3	4	
5	I have felt panic or terror	0	1	2	3	4	
6	I made plans to end my life	0	1	2	3	4	
7	I have had difficulty getting to sleep or staying asleep	0	1	2	3	4	
8	I have felt despairing or hopeless	0	1	2	3	4	
9	I have felt unhappy	0	1	2	3	4	
10	Unwanted images or memories have been distressing me	0	1	2	3	4	

Total (Clinical Score*)

***Quick scoring if all items completed: add together the item scores to get the Clinical Score.**
It is not recommended to compute a score if more than one item was omitted but if nine were completed:
add together the item scores, divide by nine to get the mean score, then multiply by 10 to get the Clinical Score.

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

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