###### 5p Positive Counseling

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Gender: [ ] Male [ ] Female Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Adult**

*If the measure is being completed by an informant, what is your relationship with the individual? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

In a typical week, approximately how much time do you spend with the individual? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that

best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?  **Slight = less than 1 or 2 days, Mild = Several Days, Severe = Nearly every day**. | **None** | **Slight** | **Mild** | **Moderate** | **Severe** |
| I | 1 | Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 | 4 |
|  | 2 | Feeling down, depressed, or hopeless? | 0 | 1 | 2 | 3 | 4 |
| II | 3 | Feeling more irritated, grouchy, angry than usual? | 0 | 1 | 2 | 3 | 4 |
| III | 4 | Sleeping less than usual, but still have a lot of energy? | 0 | 1 | 2 | 3 | 4 |
|  | 5 | Starting lots more projects than usual or doing more risky things than usual? | 0 | 1 | 2 | 3 | 4 |
| IV | 6 | Feeling nervous, anxious, frightened, worried, or on edge? | 0 | 1 | 2 | 3 | 4 |
|  | 7 | Feeling panic or being frightened? | 0 | 1 | 2 | 3 | 4 |
|  | 8 | Avoiding situations that make you anxious? | 0 | 1 | 2 | 3 | 4 |
| V | 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 |
| VI | 11 | Thoughts of actually hurting yourself? | 0 | 1 | 2 | 3 | 4 |
| VII | 12 | Hearing things that other people could not hear, such as voices even when no one was around? | 0 | 1 | 2 | 3 | 4 |
|  | 13 | Feeling that someone could hear your thoughts, or that you could hear what another person was thinking? | 0 | 1 | 2 | 3 | 4 |
| VIII | 14 | Problems with sleep that affected your sleep quality over all? | 0 | 1 | 2 | 3 | 4 |
| IX | 15 | Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)? | 0 | 1 | 2 | 3 | 4 |
| X | 16 | Unpleasant thoughts, urges, or images that repeatedly enter your mind? | 0 | 1 | 2 | 3 | 4 |
|  | 17 | Feeling driven to perform certain behaviors or mental acts over and over again? | 0 | 1 | 2 | 3 | 4 |
| XI | 18 | Feeling detached or distant from yourself, your body, your physical surroundings, or your memories? | 0 | 1 | 2 | 3 | 4 |
| XII | 19 | Not knowing who you really are or what you want out of life? | 0 | 1 | 2 | 3 | 4 |
|  | 20 | Not feeling close to other people or enjoying your relationships with them? | 0 | 1 | 2 | 3 | 4 |
| XIII | 21 | Drink at least 3 drinks of any kind of alcohol in a single day? | 0 | 1 | 2 | 3 | 4 |
|  | 22 | Smoke any cigarettes, a cigar, or pipe, or use snuff or chewing tobacco? | 0 | 1 | 2 | 3 | 4 |
|  | 23 | Use any of the following medicines ON YOUR OWN, that is, without a doctor’s prescription, in greater amounts or longer than prescribed (e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium(, or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0 | 1 | 2 | 3 | 4 |

**Please check any of the statements you believe may be true of yourself:**

Life Changes in the past year:

* I have experienced the death of a loved one
* I have married
* I have divorced
* I have moved
* I have experienced trauma (physical and/or emotional)

Life Experiences

* I have served overseas in the military. When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I have been raped or sexually assaulted. When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I have experienced trauma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I have been arrested. When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I have attempted suicide. When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep: On average, I get \_\_\_\_\_\_\_\_\_\_\_\_ hours of sleep each night

* My sleeping habits have changed recently
* I have trouble getting to sleep
* I have trouble staying asleep
* I sleep too much
* I don’t need much sleep; I feel rested with only a little sleep.

Eating Habits:

* I have little or no appetite.
* I want to eat more than usual.

Energy Level:

* I have less energy than I did before.
* I feel restless.

Thought Processes:

* I have difficulty concentrating.
* I have difficulty making decisions.
* I have difficulty remembering Short Term
* I have difficulty remember Long Term
* I am easily distracted.
* I am driven to meet my goals.
* Pictures in my head that I find difficult to stop
* Repetitive behaviors that I find difficult to stop
* Excessive fear(s) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chemicals:

* I consume alcohol (please circle): Beer Wine Liquor   
  How many drinks per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Someone else has indicated to me that they think I have a problem with drinking.
* I think I have a drinking problem.
* I used to drink alcohol, but I quit (specify when): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I smoke cigarettes. How many packs/day? \_\_\_\_\_\_\_\_\_\_\_\_ I quit smoking (when?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I use illegal drugs. Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medical conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medications (please include dosage): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please check if you have experienced the following Physical symptoms **in the last two weeks**:

* Rapid Heartbeat
* Excessive sweating
* Trembling
* Shortness of breath
* Unable to catch my breath
* Choking
* Chest Pain/Discomfort
* Nausea
* Abdominal Distress
* Dizzy/Lightheaded/Fainting
* Numbness or Tingling Sensations
* Chills or Hot Flashes
* Restlessness
* Easily Fatigued
* Cycling thoughts