**Name:**

**Date of Birth**:       **Current Date**:

**CURRENT ISSUES**

**What are the basic problem(s) you are seeking help for?**

1.

2.

3.

4.

**What are your treatment goals?**

**Current Psychiatric Symptoms Checklist: (check Symptoms you experience currently or frequently)**

**[ ]  Depressed mood**

**[ ]  Unable to enjoy life**

**[ ]  Sleeping Too Much**

**[ ]  Sleeping Too Little**

**[ ]  Early Waking**

**[ ]  Trouble Falling Asleep**

**[ ]  Unable to enjoy life**

**[ ]  Loss of interest**

**[ ]  Memory Problems**

**[ ]  Excessive Guilty Feelings**

**[ ]  Fatigue / Decreased Energy**

**[ ]  Poor Concentration**

**[ ]  Increased Appetite**

**[ ]  Decreased Appetite**

**[ ]  Weight Loss**

**[ ]  Hearing Things / Psychosis**

**[ ]  Suicidal Feelings**

**[ ]  Decreased Sex Drive**

**[ ]  Crying spells**

**[ ]  Low Self-Esteem**

**[ ]  Feelings of Hopelessness**

**[ ]  Grandiosity**

**[ ]  Irritabilty**

**[ ]  Decrease need for sleep**

**[ ]  Rapid Speech**

**[ ]  Racing thoughts**

**[ ]  Distractibility**

**[ ]  Increased Drive**

**[ ]  Physical Agitation**

**[ ]  Increased Sex Drive**

**[ ]  Spending Too Much Money**

**[ ]  Increased Risk Taking**

**[ ]  Excessive Energy**

**[ ]  Excessive worry**

**[ ]  Feeling Restless/ Keyed Up**

**[ ]  Physical or Mental Fatigue**

**[ ]  Poor Concentration**

**[ ]  Irritability**

**[ ]  Muscle Tension**

**[ ]  Discrete Episode of Fear**

**[ ]  Racing Heart**

**[ ]  Sweating**

**[ ]  Trembling**

**[ ]  Shortness of Breath**

**[ ]  Feeling of Choking**

**[ ]  Chest Pain**

**[ ]  Nausea**

**[ ]  Dizziness**

**[ ]  Derealization**

**[ ]  Fear of being Crazy**

**[ ]  Fear of Dying**

**[ ]  Sensory Changes**

**[ ]  Chills or Hot Flushes**

**[ ]  Social Fears and Anxiety**

**[ ]  Avoidance of Social Events**

**[ ]  Obsessive Thinking**

**[ ]  Compulsive Behaviors**

**[ ]  Refusal to Maintain Weight**

**[ ]  Irrational Fear over Weight**

**[ ]  Disturbed Body Image**

**[ ]  Loss of Your Period**

**[ ]  Food Binging**

**[ ]  Purging or Restriction**

**[ ]  Hallucinations / Voices**

**[ ]  Delusions**

**[ ]  Disorganized Speech**

**[ ]  Disorganized Behavior**

**[ ]  Personality Blunting**

**[ ]  Concentration Trouble**

**[ ]  Careless Mistakes**

**[ ]  Can’t Sustain Attention**

**[ ]  Poor Listening**

**[ ]  Failure to Finish**

**[ ]  Instructions Difficulty**

**[ ]  Poor Organizing Capacities**

**[ ]  Avoids Mental Effort**

**[ ]  Loses Things**

**[ ]  Easily Distracted**

**[ ]  Forgetful of daily activities**

**[ ]  Constant Fidgets /Tapping**

**[ ]  Getting Out of Seat**

**[ ]  Difficulty with Quiet Time**

**[ ]  Climbing**

**[ ]  Excessive Talking**

**[ ]  Difficultly Waiting for Turn**

**[ ]  Blurting out Answers**

**[ ]  Interrupts Others**

**[ ]  Poor Self Esteem**

**[ ]  Tendency to Frustration**

**[ ]  Quitting Easily**

**Details Regarding the Above Symptoms:**

**SUICIDE RISK ASSESSMENT**

Have you ever had feelings or thoughts that you didn’t want to live? Y [ ]  N [ ]

 If YES, please answer the following. If NO, please skip to ***Past Psychiatric History***

Do you **currently** feel that you don’t want to live? Y [ ]  N [ ]

How often do you have these thoughts?

When was the last time you had thoughts of dying?

Has anything happened recently to make you feel this way?

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?

Would anything make it better?

Have you ever thought about how you would kill yourself? Y [ ]  N [ ]  Details:

Is the method you would use readily available? Y [ ]  N [ ]

Have you planned a time for this? Y [ ]  N [ ]  Details:

Is there anything that would stop you from killing yourself? Y [ ]  N [ ]  Details:

Do you feel hopeless and /or worthless? Y [ ]  N [ ]

Have ever tried to kill or harm yourself before? Y [ ]  N [ ]  Details:

**PAST PSYCHIATRIC HISTORY**

**Have you previously engaged outpatient psychiatric treatment?** Y [ ]  N [ ]

 Details:

**Have you ever been in the psychiatric hospital?** Y [ ]  N [ ]

 Details:

**PERSONAL and FAMILY PAST PSYCH HISTORY:**

 **Have you or a member of your family had of any of the following Diagnoses or Conditions?**

|  |  |  |  |
| --- | --- | --- | --- |
| Diagnosis / Condition | You | Family | Details (if not explained elsewhere) |
| Now | Past |
| Depression | [ ]  | [ ]  | [ ]  |       |
| Suicidal Feeling | [ ]  | [ ]  | [ ]  |       |
| Suicide Attempt | [ ]  | [ ]  | [ ]  |       |
| Bipolar Disorder  | [ ]  | [ ]  | [ ]  |       |
| Anxiety | [ ]  | [ ]  | [ ]  |       |
| Panic | [ ]  | [ ]  | [ ]  |       |
| Phobias | [ ]  | [ ]  | [ ]  |       |
| PTSD | [ ]  | [ ]  | [ ]  |       |
| Alcoholism | [ ]  | [ ]  | [ ]  |       |
| Drug Addiction | [ ]  | [ ]  | [ ]  |       |
| Assault/Rage | [ ]  | [ ]  | [ ]  |       |
| Psychosis | [ ]  | [ ]  | [ ]  |       |
| Schizophrenia | [ ]  | [ ]  | [ ]  |       |
| Anorexia | [ ]  | [ ]  | [ ]  |       |
| Bulemia | [ ]  | [ ]  | [ ]  |       |
| OCD | [ ]  | [ ]  | [ ]  |       |
| Hoarding | [ ]  | [ ]  | [ ]  |       |
| Dementia | [ ]  | [ ]  | [ ]  |       |
| ADHD | [ ]  | [ ]  | [ ]  |       |
| Dyslexia | [ ]  | [ ]  | [ ]  |       |
| Learning Disability | [ ]  | [ ]  | [ ]  |       |
| Autism/Asperger’s | [ ]  | [ ]  | [ ]  |       |
| Other:       | [ ]  | [ ]  | [ ]  |       |
| Other:       | [ ]  | [ ]  | [ ]  |       |

**Past Psychiatric Medications:** please check past medications and indicate the details below.

**Antidepressants**

[ ] Prozac (fluoxetine) - [ ] Zoloft (sertraline) - [ ] Luvox (fluvoxamine) - [ ] Paxil (paroxetine) - [ ] Celexa (citalopram) –

[ ] Lexapro (escitalopram) - [ ] Effexor (venlafaxine) - [ ] Cymbalta (duloxetine) - [ ] Wellbutrin (bupropion) - [ ] Remeron (mirtazapine) – [ ] Vybrid (vilazodone ) – [ ] Parnate (trancypromine) – [ ] Emsam (selegiline) - [ ] Serzone (nefazodone) –

[ ] Anafranil (clomipramine) - [ ] Pamelor (nortrptyline) - [ ] Tofranil (imipramine) - [ ] Elavil (amitriptyline) - [ ] Deplin (methyfolate)

**Mood Stabilizers**

[ ] Tegretol (carbamazepine) - [ ] Lithium - [ ] Depakote (valproate) - [ ] Lamictal (lamotrigine) - [ ] Tegretol (carbamazepine) – [ ] Trileptal (oxcarbamazipine) - [ ] Topamax (topiramate)

**Antipsychotics/Mood Stabilizers**

[ ] Seroquel (quetiapine) - [ ] Zyprexa (olanzepine) - [ ] Geodon (ziprasidone) - [ ] Abilify (aripiprazole) - [ ] Clozaril (clozapine) – [ ] Fanapt (iloperidone) – [ ] Saphris (asenapine) – [ ] Latuda (lurasidone) – [ ] Invega (paliperidone) - [ ] Haldol (haloperidol) - [ ] Prolixin (fluphenazine)

**Sedative/Hypnotics and Anti-anxiety**

[ ] Ambien (zolpidem) – [ ] Lunesta (eszolpiclone) - [ ] Sonata (zaleplon) - [ ] Rozerem (ramelteon) - [ ] Restoril (temazepam) - [ ] Desyrel (trazodone) - [ ] Xanax (alprazolam) - [ ] Ativan (lorazepam) - [ ] Klonopin (clonazepam) - [ ] Valium (diazepam) - [ ] Buspar (buspirone)

**ADHD medications**

[ ] Adderall (amphetamine) – [ ] Vyvanse (lisdexamphetamine) - [ ] Concerta (methylphenidate) - [ ] Ritalin (methylphenidate) - [ ] Strattera (atomoxetine) - [ ] Selegiline

|  |  |  |  |
| --- | --- | --- | --- |
| Past Medication | Dosage | Effects / Response | Side Effects |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
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|       |       |       |       |

**Has any family member been treated with psychiatric medications?** Y [ ]  N [ ]

Details:

**MEDICAL HISTORY**

**Approximate Date and place of last physical exam**:

**All current MEDICATIONS (Prescription and OTC):**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Dosage | Directions | Side Effects |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
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|       |       |       |       |

**All current SUPPLEMENTS, HERBS or NUTRIENTS:**

|  |  |  |  |
| --- | --- | --- | --- |
| Supplement Name | Dosage | Directions | Effects and Side Effects |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
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|       |       |       |       |
|       |       |       |       |

**Current and Past MEDICAL CONDITIONS and SURGERIES:**

|  |  |  |
| --- | --- | --- |
| Medical Condition | Current | For How Long? Details. |
| Y | N |
|       | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  |       |

**Have you ever had an EKG**? Y [ ]  N [ ]  If yes, when?

 Why?       Was the EKG: [ ]  Normal [ ]  Abnormal [ ]  Unknown**?**

**Have you ever had an MRI or CAT Scan**? Y [ ]  N [ ]  If yes, when?

 Why?       Was the scan [ ]  Normal [ ]  Abnormal [ ]  Unknown**?**

**Your Exercise Level:**

Do you exercise regularly? Y [ ]  N [ ]

How many days a week do you get exercise?

What kind of exercise do you get?

Do you feel better with exercise? Y [ ]  N [ ]

Do you feel “wiped out” or recover very slowly with exercise? Y [ ]  N [ ]

**Diet:**

Do you eat meat?Y [ ]  N [ ]  Vegan? Y [ ]  N [ ]  Vegetarian Y [ ]  N [ ]  Organic? Y [ ]  N [ ]

How many servings of Vegetables       and Fruits       do you get on average every day?

How many caffeinated beverages do you drink a day?Coffee       Sodas       Tea

**Tobacco History:**

Have you smoked cigarettes regularly? Y [ ]  N [ ]  Currently? Y [ ]  N [ ]

Packs per day on average?       How many years?       When did you quit?

Use pipe, cigars, or chewing tobacco currently? Y [ ]  N [ ]

What kind?       How often per day on average?       How many years?

**For Women Only:**

Are you currently pregnant or do you think you might be pregnant? Y [ ]  N [ ]

 Are you planning to be pregnant soon? Y [ ]  N [ ]  Birth control method:

 How many times have you been pregnant?       How many live births?

 Is menstrual cycle irregular? Y [ ]  N [ ]  Details:

 Is your menstrual cycle regular without birth control pills? Y [ ]  N [ ]

 What is your Pattern? Every       days, Light [ ]  Medium [ ]  Heavy [ ] , lasting       days.

 Do your Mood Symptoms worsen at a specific time in your cycle? Y [ ]  N [ ]  Details:

**Were there any complications during your birth or your mother’s pregnancy?**

Details:

**Describe your SLEEP patterns**:

Do you ever get night sweats? Y [ ]  N [ ]  Do you wake up with a pounding heart? Y [ ]  N [ ]

Has anything bad happened in the past while you were sleeping? Y [ ]  N [ ]

How many hours before bedtime do you eat?       Are your legs uncomfortable in bed? Y [ ]  N [ ]

Do you stop breathing while you sleep?  Y [ ]  N [ ]  Do you ever wake up gasping for breath? Y [ ]  N [ ]

Can you breathe easily through your nose? Y [ ]  N [ ]  Do you “walk off” leg discomfort at bed? Y [ ]  N [ ]

If you didn’t need to get up at a specific time would you start going to bed later and later? Y [ ]  N [ ]

Do you resist falling asleep only to get a “second wind” . . . that you are no longer tired? Y [ ]  N [ ]

How long does it take to feel awake in the morning?

Do you feel in the morning as if you were barely asleep the whole night? Y [ ]  N [ ]

**Substance Use:**

Are you now or have you been sober in the past? Y [ ]  N [ ]

 Details:

Have you ever been treated for alcohol or drug use or abuse (Rehab)? Y [ ]  N [ ]

How many days per week do you drink alcohol?

What is the least number of drinks you will drink in a day?       The most?

Consequences? [ ]  Blackouts [ ]  Withdrawal [ ]  DUI [ ]  Relationship [ ]  Job [ ]  Health

Have you ever felt you ought to cut down on your drinking or drug use? Y [ ]  N [ ]

Have people annoyed you by criticizing your drinking or drug use? Y [ ]  N [ ]

Have you ever felt bad or guilty about your drinking or drug use? Y [ ]  N [ ]

Do you drink or used drugs in the morning to steady your nerves? Y [ ]  N [ ]

Do you think you may have a problem with alcohol or drug use? Y [ ]  N [ ]

Is Marijuana a problem for you? Y [ ]  N [ ]

**Circle if you have ever used or had trouble with, or simply want to discuss any of the following:**

[ ]  Methamphetamine [ ]  Cocaine [ ]  Stimulants (pills) [ ]  Heroin [ ]  Pain killers

[ ]  Vicodin [ ]  Methadone [ ]  Oxycontin [ ]  LSD [ ]  Mushrooms

[ ]  Ecstasy [ ]  Ketamine [ ]  Marijuana [ ]  Tranquilizers [ ]  Sleeping pills

[ ]  Other – Details:

Have any specific drugs made you feel better? Details:

Have any specific drugs made you feel worse? Details:

**MEDICAL CHECKLIST / REVIEW OF SYSTEMS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Condition | You | Family Member? | Condition | You | Family Member? |
| Now | Past | Now | Past |
| Anemia | [ ]  | [ ]  | [ ]  | Cancer:      | [ ]  | [ ]  | [ ]  |
| Low B12 | [ ]  | [ ]  | [ ]  | Cancer:      | [ ]  | [ ]  | [ ]  |
| Low Iron  | [ ]  | [ ]  | [ ]  | Low Cholesterol | [ ]  | [ ]  | [ ]  |
| Chronic Fatigue  | [ ]  | [ ]  | [ ]  | High Cholesterol | [ ]  | [ ]  | [ ]  |
| Dizzy when Standing | [ ]  | [ ]  | [ ]  | Obesity/Overweight | [ ]  | [ ]  | [ ]  |
| Blood Sugar Lows | [ ]  | [ ]  | [ ]  | Weight Loss | [ ]  | [ ]  | [ ]  |
| Trouble Waking in Morn | [ ]  | [ ]  | [ ]  | Heart Disease | [ ]  | [ ]  | [ ]  |
| Poor exercise tolerance | [ ]  | [ ]  | [ ]  | Heart Attack/MI  | [ ]  | [ ]  | [ ]  |
| Energy Peaks in Eve | [ ]  | [ ]  | [ ]  | High blood pressure | [ ]  | [ ]  | [ ]  |
| Hives  | [ ]  | [ ]  | [ ]  | Chest Pain | [ ]  | [ ]  | [ ]  |
| Skin Itching | [ ]  | [ ]  | [ ]  | Palpitations | [ ]  | [ ]  | [ ]  |
| Eczema | [ ]  | [ ]  | [ ]  | Heart Attack | [ ]  | [ ]  | [ ]  |
| Psoriasis | [ ]  | [ ]  | [ ]  | Irregular Heartbeat | [ ]  | [ ]  | [ ]  |
| Fibromyalgia | [ ]  | [ ]  | [ ]  | Hemophilia | [ ]  | [ ]  | [ ]  |
| Non-restful sleep | [ ]  | [ ]  | [ ]  | Easy Bruising  | [ ]  | [ ]  | [ ]  |
| Restless legs at Sleep  | [ ]  | [ ]  | [ ]  | Liver Disease | [ ]  | [ ]  | [ ]  |
| Aching Legs at Rest | [ ]  | [ ]  | [ ]  | Thyroid Disease | [ ]  | [ ]  | [ ]  |
| Ulcers / Gastritic | [ ]  | [ ]  | [ ]  | Sig weight gain | [ ]  | [ ]  | [ ]  |
| Acid Reflux | [ ]  | [ ]  | [ ]  | Tendency to be cold | [ ]  | [ ]  | [ ]  |
| Constipation | [ ]  | [ ]  | [ ]  | Sleep Apnea | [ ]  | [ ]  | [ ]  |
| Diarrhea | [ ]  | [ ]  | [ ]  | Sleep Attacks in Day | [ ]  | [ ]  | [ ]  |
| Bloating | [ ]  | [ ]  | [ ]  | Daytime Sleepiness | [ ]  | [ ]  | [ ]  |
| Migraines | [ ]  | [ ]  | [ ]  | Diabetes | [ ]  | [ ]  | [ ]  |
| Food Allergies | [ ]  | [ ]  | [ ]  | Frequesnt Urination | [ ]  | [ ]  | [ ]  |
| Frequent Antibiotics | [ ]  | [ ]  | [ ]  | Chronic Pain  | [ ]  | [ ]  | [ ]  |
| Sinusitis | [ ]  | [ ]  | [ ]  | Epilepsy/Seizures  | [ ]  | [ ]  | [ ]  |
| Frequent UTIs | [ ]  | [ ]  | [ ]  | Head trauma/injury | [ ]  | [ ]  | [ ]  |
| Frequent Yeast Infxns | [ ]  | [ ]  | [ ]  | Polycystic Ovaries | [ ]  | [ ]  | [ ]  |
| Asthma/Respiratory | [ ]  | [ ]  | [ ]  | Irregular Period | [ ]  | [ ]  | [ ]  |
| Easily get Colds | [ ]  | [ ]  | [ ]  | Significant Weight Flux | [ ]  | [ ]  | [ ]  |
| Frequent Strep Throat | [ ]  | [ ]  | [ ]  | Hair on chin (women) | [ ]  | [ ]  | [ ]  |
| Serious Infection | [ ]  | [ ]  | [ ]  | Kidney Disease  | [ ]  | [ ]  | [ ]  |
| Mono/EpsteinBarr Virus | [ ]  | [ ]  | [ ]  | Pain with Urination  | [ ]  | [ ]  | [ ]  |
| Weight Loss | [ ]  | [ ]  | [ ]  | Difficulty Urinating  | [ ]  | [ ]  | [ ]  |
| Unexplained Fevers | [ ]  | [ ]  | [ ]  | Pain with Orgasm | [ ]  | [ ]  | [ ]  |
| Diabetes | [ ]  | [ ]  | [ ]  | Frequent Waking to Pee | [ ]  | [ ]  | [ ]  |
| Excessive Thirst | [ ]  | [ ]  | [ ]  | Other:        | [ ]  | [ ]  | [ ]  |
| Other:        | [ ]  | [ ]  | [ ]  | Other:        | [ ]  | [ ]  | [ ]  |
| Other:        | [ ]  | [ ]  | [ ]  | Other:        | [ ]  | [ ]  | [ ]  |
| Other:        | [ ]  | [ ]  | [ ]  | Other:        | [ ]  | [ ]  | [ ]  |
| Other:        | [ ]  | [ ]  | [ ]  | Other:        | [ ]  | [ ]  | [ ]  |

Details (if not explained elsewhere):

**FAMILY BACKGROUND and CHILDHOOD HISTORY**

**Background:** Were you adopted? Y [ ]  N [ ]

Where did you grow up?

List your siblings and their ages:

Father’s occupation?       Mother’s Occupation?       Did your parents’ divorce? Y [ ]  N [ ]  If so, how old were you when they divorced?

Describe your father and your relationship with him:

Describe your mother and your relationship with her:

**Trauma History:**

Do you have a history of being abused emotionally, sexually, physically or by neglect? Y [ ]  N [ ]

Details (if you are comfortable writing . . . or can discuss in office):

**Educational History:**

Did you attend college? Y [ ]  N [ ]  Where?       Major?

What is your highest educational level or degree attained?

**Occupational History:**

Are you currently: [ ]  Working [ ]  Not working by choice [ ]  Unemployed [ ]  Disabled [ ]  Retired

How long in present position?

What is/was your occupation?

Are you happy with your work?

**Relationship History and Current Family:**

Are you currently: [ ]  Married [ ]  Divorced [ ]  Single [ ]  Widowed Details:

If not married, are you currently in a relationship? Y [ ]  N [ ]  How long?

Are you sexually active? Y [ ]  N [ ]

How would you identify your sexual orientation? [ ] straight/heterosexual [ ] lesbian/gay/homosexual

 [ ] bisexual [ ] transsexual [ ] unsure/questioning [ ] asexual [ ] other [ ] prefer not to answer

What is your spouse or significant other’s occupation?

Describe your relationship with your spouse or significant other:

Have you had any prior marriages? Y [ ]  N [ ]  If so, how many?

Describe any details regaring your marriage that are relevant:

Children? Y [ ]  N [ ]  How many?       What are their ages?

Describe your relationship with your children:

**Legal:** Have you ever been arrested? Y [ ]  N [ ]

Do you have any pending legal problems? Y [ ]  N [ ]  Details:

**Spiritual life:** Do you belong to a religion or spiritual group? Y [ ]  N [ ]  Which?

 Have you ever had experiences of “Awe” or “Transcendence”? Y [ ]  N [ ]

Details:

**Is there anything else that you would like your doctor to know?**

**Emotional Distress – Anxiety – Short Form 8a**

PROMIS Item Bank v1.0 – Emotional Distress – Anxiety – Short Form 8a

Investigator Format © 2008-2012 PROMIS Health Organization and PROMIS Cooperative Group

Page 1 of 1

**Please respond to each question or statement by marking one box per row.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **In the past 7 days…**  | **Never**  | **Rarely**  | **Sometimes**  | **Often**  | **Always**  |
| EDANX01 1  | I felt fearful  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDANX40 2  | I found it hard to focus on anything other than my anxiety  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDANX41 3  | My worries overwhelmed me  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDANX53 4  | I felt uneasy  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDANX46 5  | I felt nervous  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDANX07 6  | I felt like I needed help for my anxiety  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDANX05 7  | I felt anxious  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDANX54 8  | I felt tense  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |

**Emotional Distress – Depression – Short Form 8a**

PROMIS Item Bank v1.0 – Emotional Distress – Depression–Short Form 8a

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**Please respond to each question or statement by marking one box per row.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **In the past 7 days…**  | **Never**  | **Rarely**  | **Sometimes**  | **Often**  | **Always**  |
| EDDEP04 1  | I felt worthless | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDDEP062  | I felt helpless  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDDEP293  | I felt depressed  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDDEP41 4  | I felt hopeless  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDDEP22 5  | I felt like a failure  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDDEP36 6  | I felt unhappy | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDDEP05 7  | I felt that I had nothing to look forward to  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| EDDEP09 8  | I felt that nothing could cheer me up  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |

**Fatigue – Short Form 8a**

PROMIS Item Bank v1.0 – Fatigue – Short Form 8a

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**Please respond to each question or statement by marking one box per row.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **During the past 7 days…**  | **Not at all**  | **A little bit**  | **Somewhat**  | **Quite a bit**  | **Very much**  |
| HI7 1  | I feel fatigued  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| AN3 2  | I have trouble starting things because I am tired  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| **In the past 7 days…**  |
| FATEXP41 3  | How run-down did you feel on average? ...  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| FATEXP40 4  | How fatigued were you on average?  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| FATEXP35 5  | How much were you bothered by your fatigue on average?  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| FATIMP49 6  | To what degree did your fatigue interfere with your physical functioning?  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| **In the past 7 days…**  | **Never**  | **Rarely**  | **Sometimes**  | **Often**  | **Always**  |
| FATIMP3 7  | How often did you have to push yourself to get things done because of your fatigue?  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |
| FATIMP16 8  | How often did you have trouble finishing things because of your fatigue?  | [ ] 1  | [ ] 2  | [ ] 3  | [ ] 4  | [ ] 5  |

**Sleep Disturbance – Short Form 8a**

PROMIS Item Bank v1.0 – Sleep Disturbance – Short Form 8a

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**Please respond to each question or statement by marking one box per row.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **In the past 7 days…**  | **Very poor**  | **Poor**  | **Fair**  | **Good**  | **Very good**  |
| Sleep109 1  | My sleep quality was  | [ ] 5  | [ ] 4  | [ ] 3  | [ ] 2  | [ ] 1  |
| **In the past 7 days…**  | **Not at all**  | **A little bit**  | **Somewhat**  | **Quite a bit**  | **Very much**  |
| Sleep116 2  | My sleep was refreshing.  | [ ] 5  | [ ] 4  | [ ] 3  | [ ] 2  | [ ] 1  |
| Sleep20 3  | I had a problem with my sleep  | [ ] 1 | [ ] 2 | [ ] 3  | [ ] 4 | [ ] 5 |
| Sleep44 4  | I had difficulty falling asleep  | [ ] 1 | [ ] 2 | [ ] 3  | [ ] 4 | [ ] 5 |
| Sleep108 5  | My sleep was restless  | [ ] 1 | [ ] 2 | [ ] 3  | [ ] 4 | [ ] 5 |
| Sleep72 6  | I tried hard to get to sleep  | [ ] 1 | [ ] 2 | [ ] 3  | [ ] 4 | [ ] 5 |
| Sleep67 7  | I worried about not being able to fall asleep  | [ ] 1 | [ ] 2 | [ ] 3  | [ ] 4 | [ ] 5 |
| Sleep115 8  | I was satisfied with my sleep.  | [ ] 5  | [ ] 4  | [ ] 3  | [ ] 2  | [ ] 1  |