

# SAMPLE

## CLINICAL OUTCOMES in ROUTINE EVALUATION

### OUTCOME MEASURE

Site ID	<input type="text"/>						Age	<input type="text"/>		Male	<input type="checkbox"/>
letters only	<input type="text"/>	numbers only	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				Female	<input type="checkbox"/>
Client ID	<input type="text"/>	Therapist ID	<input type="text"/>	numbers only (1)	<input type="text"/>	numbers only (2)	<input type="text"/>	<input type="text"/>	Stage Completed		
Sub codes	<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		
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"/>	Episode		
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<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		

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 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.  
*Please use a dark pen (not pencil) and tick clearly within the boxes.*

	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	
1 I have felt terribly alone and isolated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	F
2 I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	P
3 I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	F
4 I have felt O.K. about myself	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	W
5 I have felt totally lacking in energy and enthusiasm	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	P
6 I have been physically violent to others	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	R
7 I have 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	F
8 I have been troubled by aches, pains or other physical problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	P
9 I have thought of hurting myself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	R
10 Talking to people has 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	F
11 Tension and anxiety have prevented me doing important things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	P
12 I have been happy with the things I have done.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	F
13 I have been disturbed by unwanted thoughts and feelings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	P
14 I have felt like crying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	W

Please turn over

# SAMPLE

Over the last week

Not at all    Only Occasionally    Sometimes    Often    Most of all the time  
 OFFICE USE ONLY

		0	1	2	3	4	
15	I have felt panic or terror	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P
16	I made plans to end my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R
17	I have felt overwhelmed by my problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	W
18	I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P
19	I have felt warmth or affection for someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F
20	My problems have been impossible to put to one side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P
21	I have been able to do most things I needed to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F
22	I have threatened or intimidated another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R
23	I have felt despairing or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P
24	I have thought it would be better if I were dead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R
25	I have felt criticised by other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F
26	I have thought I have no friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F
27	I have felt unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P
28	Unwanted images or memories have been distressing me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P
29	I have been irritable when with other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F
30	I have thought I am to blame for my problems and difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P
31	I have felt optimistic about my future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	W
32	I have achieved the things I wanted to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F
33	I have felt humiliated or shamed by other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F
34	I have hurt myself physically or taken dangerous risks with my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

**Total Scores**

<input style="width: 50px; height: 30px;" type="text"/>	<input style="width: 50px; height: 30px;" type="text"/>	<input style="width: 50px; height: 30px;" type="text"/>	<input style="width: 50px; height: 30px;" type="text"/>	→	<input style="width: 50px; height: 30px;" type="text"/>	→	<input style="width: 50px; height: 30px;" type="text"/>
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**Mean Scores**

(Total score for each dimension divided by number of items completed in that dimension)

<input style="width: 50px; height: 30px;" type="text"/>	<input style="width: 50px; height: 30px;" type="text"/>	<input style="width: 50px; height: 30px;" type="text"/>	<input style="width: 50px; height: 30px;" type="text"/>	<input style="width: 50px; height: 30px;" type="text"/>	<input style="width: 50px; height: 30px;" type="text"/>
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(W)                      (P)                      (F)                      (R)                      All items                      All minus R

