Date:

Name:

Date of Birth:

Hospital Number:

# Wellbeing Questionnaire

1. This bundle of questionnaires is designed to help assess wellbeing. The information will help us offer you the most appropriate treatment.
2. **Remember to insert the date of scoring the questions.**
3. Please note that there are **EIGHT separate questionnaires** in this bundle. You need to **complete them ALL.**
4. Please collate the scores in the table below.

| | Questionnaire | Score |
|---|---|---|
| 1. | GAD-7 (DSM-5) | |
| 2. | Patient Health Questionnaire-9 (DSM-5) | |
| 3. | Impact of Events Scale (IES – 6) | |
| 4. | Clinical Outcomes in Routine Evaluation- (CORE-10) | |
| 5. | Insomnia Severity Index (ISI) | |
| 6. | Epworth Sleepiness Questionnaire (ESS) | |
| 7. | Fatigue Severity Score (FSS) | |
| 8. | Toronto Hospital Alertness Test (THAT) | |

| Date: |
|---|

| Name: |
|---|
| DOB: |
| Hosp No: |

# GAD – 7 Scale

| Over the last week, how often have you been bothered by the following problems? | | | | | |
|---|---|---|---|---|---|
| | | Not at all | Several days | More than half the days | Nearly every day |
| 1. | Feeling nervous, anxious, or on edge. (Aa) | 0 | 1 | 2 | 3 |
| 2. | Not being able to stop or control worrying.(B) | 0 | 1 | 2 | 3 |
| 3. | Worrying too much about different things.(Ab) | 0 | 1 | 2 | 3 |
| 4. | Trouble relaxing.(C5) | 0 | 1 | 2 | 3 |
| 5. | Being so restless that it is hard to sit still.(C1) | 0 | 1 | 2 | 3 |
| 6. | Becoming easily annoyed or irritable.(C4) | 0 | 1 | 2 | 3 |
| 7. | Feeling afraid as if something awful might happen.(Ab) | 0 | 1 | 2 | 3 |
| | Add score for each column | | | | |
| | **TOTAL** | | | | |

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? **Please circle only one.**

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

(DSM-5: a214637859)

**Please circle the answer that fits best for you based on the last two weeks.**

| | | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|---|
| **1.** | **Little interest or pleasure in doing things (a2).** | **0** | **1** | **2** | **3** |
| **2.** | **Feeling down, depressed, or hopeless (a1).** | **0** | **1** | **2** | **3** |
| 3. | Trouble falling or staying asleep, or sleeping too much (a4). | 0 | 1 | 2 | 3 |
| 4. | Feeling tired or having little energy (a6). | 0 | 1 | 2 | 3 |
| 5. | Poor appetite or overeating (a3). | 0 | 1 | 2 | 3 |
| 6. | Feeling bad about yourself or that you are a failure or that you have let yourself or your family down (a7). | 0 | 1 | 2 | 3 |
| 7. | Trouble concentrating on things, such as reading the newspaper or watching TV (a8). | 0 | 1 | 2 | 3 |
| 8. | Moving or speaking so slowly that other people could have noticed; (a5)<br>**Or the opposite,**<br>Being so fidgety or restless that you have been moving around a lot more than usual. | 0 | 1 | 2 | 3 |
| 9. | Thoughts that you would be better off dead **OR** of hurting yourself in some way (a9). | 0 | 1 | 2 | 3 |
| | **TOTAL = /27** | | | | |

| 10. | If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | | | |
|---|---|---|---|---|
| | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
| | 0 | 1 | 2 | 3 |

## IES-6

The following is a list of difficulties people sometimes have after stressful life events.

**Please read each item, and then indicate how distressing each difficulty has been for you <u>during the past 7 days</u> with respect to stressful life events**.

How much were you distressed or bothered by these difficulties?

| | Not at all | A little bit | Moderately | Quite a bit | Extremely |
|---|---|---|---|---|---|
| I thought about it when I didn't mean to | 0 | 1 | 2 | 3 | 4 |
| Other things kept making me think about it | 0 | 1 | 2 | 3 | 4 |
| I was aware that I still had a lot of feelings about it, but I didn't deal with them | 0 | 1 | 2 | 3 | 4 |
| I tried not to think about it | 0 | 1 | 2 | 3 | 4 |
| I felt watchful or on-guard | 0 | 1 | 2 | 3 | 4 |
| I had trouble concentrating | 0 | 1 | 2 | 3 | 4 |

# Clinical Outcomes in Routine Evaluation (CORE-10)

- This questionnaire has 10 statements about how you have been **OVER THE LAST WEEK**
- Please read each statement and think how often you felt that way over the last week
- Then, **please tick (√) the box which is closest to this**

**Instructions for scoring CORE-10**

- Before you score the questionnaire, check you have answered all ten questions.
- Each answer has a number next to it between 0 and 4. Simply add up all ten numbers to give you a score between 0 and 40. This is the total score.
- Remember that this is just a snapshot of how things have been in the last week. Your score may vary from week to week in the normal course of events.

| Over the last week: | Not at all | Only occasionally | Sometimes | Often | Most of the time |
|---|---|---|---|---|---|
| 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 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 |
| **Add columns** | | | | | |
| **TOTAL SCORE** | | | | | |

# Insomnia Severity Index

For each question below, please circle the number corresponding most accurately to your sleep patterns in the **LAST MONTH**.

For the first three questions, please rate the **SEVERITY** of your sleep difficulties.

1. Difficulty falling asleep:

| None | Mild | Moderate | Severe | Very Severe |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

2. Difficulty staying asleep:

| None | Mild | Moderate | Severe | Very Severe |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

3. Problem waking up too early in the morning:

| None | Mild | Moderate | Severe | Very Severe |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

4. How **SATISFIED**/dissatisfied are you with your current sleep pattern?

| Very Satisfied | Satisfied | Neutral | Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

5. To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood)?

| Not at all Interfering | A little Interfering | Somewhat Interfering | Very Interfering | Extremely Interfering |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

6. How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life?

| Not at all Noticeable | A little Noticeable | Somewhat Noticeable | Very Noticeable | Extremely Noticeable |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

7. How **WORRIED**/distressed are you about your current sleep problem?

| Not at all | A little | Somewhat | Very | Extremely |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

Add your scores for all items – **TOTAL SCORE** =

# EPWORTH QUESTIONNAIRE

- Please rate how likely you are to sleep in the following situations, **BASED ON YOUR EXPERIENCE IN THE LAST MONTH.**
- We are **not asking you to rate how tired** you would be in these situations **but how likely you are to doze off.**
- If you have not been in the following situations recently, think about how you would have been affected.
- Circle the most appropriate number for each situation.

| **DATE:** | | **Would Never Doze** | **Slight Chance of Dozing** | **Moderate Chance of Dozing** | **High Chance of Dozing** |
|---|---|---|---|---|---|
| 1 | Sitting and reading | 0 | 1 | 2 | 3 |
| 2 | Watching TV | 0 | 1 | 2 | 3 |
| **3** | Sitting Inactive in a Public Place | 0 | 1 | 2 | 3 |
| 4 | As a passenger in a car for an hour | 0 | 1 | 2 | 3 |
| 5 | Lying down to rest in the afternoon | 0 | 1 | 2 | 3 |
| **6** | Sitting and talking to someone | 0 | 1 | 2 | 3 |
| 7 | Sitting quietly after lunch without alcohol | 0 | 1 | 2 | 3 |
| **8** | In a car while stopped in traffic for a few minutes | 0 | 1 | 2 | 3 |
| | | | | **Total Score** | |

# FATIGUE SEVERITY SCORE

| SURNAME | |
|---|---|
| FIRST NAME | |
| DATE OF BIRTH | |
| DATE | |

Read each statement and mark  a number from 1-7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

A low value (e.g. 1) indicates strong disagreement with the statement, whereas a high value (e.g. 7) indicates strong agreement.

It is important you circle a number (1 to 7) for every question.

**Please place a tick mark - ✓ - in the appropriate box**

| | | **Disagree** | | | | | | **Agree** |
|---|---|---|---|---|---|---|---|---|
| 1. | My motivation is lower when I am fatigued. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. | Exercise brings on my fatigue. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. | I am easily fatigued. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. | Fatigue interferes with my physical functioning. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. | Fatigue causes frequent problem for me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. | My fatigue prevents sustained physical functioning. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. | Fatigue interferes with carrying  of certain duties and responsibilities. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. | Fatigue is among my three most disabling symptoms. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. | Fatigue interferes with my work, family or social life. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| | **TOTAL =** | | | | | | | **/63** |

# <u>Toronto Hospital Alertness Test</u>

**Instructions:**

- This questionnaire tries to establish **how alert you have felt <u>over the past 7 days</u>**
- **Please select (tick ✓) one response for each question**

| **During the last 7 days I felt:** | **Not at all** | **Less 25% of the time** | **25-50% of the time** | **50-75% of the time** | **More than 75% of the time** | **All the time I was awake** |
|---|---|---|---|---|---|---|
| 1. Able to concentrate(0-5) | 0 | 1 | 2 | 3 | 4 | 5 |
| 2. Alert (0-5) | 0 | 1 | 2 | 3 | 4 | 5 |
| 3. Fresh (0-5) | 0 | 1 | 2 | 3 | 4 | 5 |
| 4. Energetic (0-5) | 0 | 1 | 2 | 3 | 4 | 5 |
| 5. Able to think of new ideas (0-5) | 0 | 1 | 2 | 3 | 4 | 5 |
| 6. Vision was clear noting all details (e.g. driving) (0-5) | 0 | 1 | 2 | 3 | 4 | 5 |
| 7. Able to focus on the task at hand (0-5) | 0 | 1 | 2 | 3 | 4 | 5 |
| 8. Mental facilities were operating at peak level (0-5) | 0 | 1 | 2 | 3 | 4 | 5 |
| 9. Extra effort was needed to maintain alertness (5-0 | 5 | 4 | 3 | 2 | 1 | 0 |
| 10. In a boring situation I would find my mind wandering (5-0) | 5 | 4 | 3 | 2 | 1 | 0 |
| **Total for column** | | | | | | |
| **Total Score** | | | | | | |