



Name:

Date:

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 choose the button which is closest to this.
Please remember to save the file when you are finished.

Over the last week

	<i>Not at all</i>	<i>Only Occasionally</i>	<i>Sometimes</i>	<i>Often</i>	<i>Most or all the time</i>
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

Please now use "Save", or the save button in your PDF reader, to save this file and send it back to the person who sent it to you.

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE