Therapist ID: Sex: Session #: Client #:

AUBURN UNIVERSITY MARRIAGE AND FAMILY THERAPY CLINIC

Family Adult Follow-up

The first section will focus on individual depression and anxiety over the last 2 weeks. Information is confidential.

		All the Time	*Most Times*	*More than Half the Time*	*Less than Half the Time*	*Some-times*	*At No Time*
1.	Have you felt low in spirits or sad?	5	4	3	2	1	0
2.	Have you lost interest in your daily activities?	5	4	3	2	1	0
3.	Have you felt lacking in energy and strength?	5	4	3	2	1	0
4.	Have you felt less self- confident?	5	4	3	2	1	0
5.	Have you had a bad conscience or feelings of guilt?	5	4	3	2	1	0
6.	Have you felt that life wasn't worth living?	5	4	3	2	1	0
7.	Have you had difficulty in concentrating, e.g. when reading the newspaper or watching TV?	5	4	3	2	1	0
8.	(A) Have you felt very restless?	5	4	3	2	1	0
	(B) Have you felt subdued or slowed down?	5	4	3	2	1	0
9.	Have you had trouble sleeping at night?	5	4	3	2	1	0
10.	(A) Have you suffered from reduced appetite?	5	4	3	2	1	0
	(B) Have you suffered from increased appetite?	5	4	3	2	1	0

		Not at All	*Several Days*	*More than Half the Days*	*Nearly Every Day*
1.	Feeling nervous, anxious or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it is hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3

		Not Difficult	*Somewhat*	*Very*	*Extremely*
8.	How difficult have these problems made it for you to do your work, take care of the home, or get along with others?	0	1	2	3

Using the following key, how often did **YOU** do the following during the PAST 4 WEEKS?

0	*1*	*2*	*3*	*4*	*5*	*6*	*7*
Never	*Once*	*Twice*	*3-5 Times*	*6-10 Times*	*11-20 Times*	*More than 20 Times*	*Happened but Not in Past Year*

1.	Threw something (but not at a family member) or smashed something	0	1	2	3	4	5	6	7
2.	Threatened to hit or throw something at a family member	0	1	2	3	4	5	6	7
3.	Threw something at family member	0	1	2	3	4	5	6	7
4.	Pushed, grabbed, or shoved a family member	0	1	2	3	4	5	6	7
5.	Hit (or tried to hit) a family member but *not* with anything hard	0	1	2	3	4	5	6	7
6.	Hit (or tried to hit) a family member with something hard	0	1	2	3	4	5	6	7

Using the same key as above, how often did **YOUR CHILD** do the following during the PAST 4 WEEKS?

1.	Threw something (but not at a family member) or smashed something	0	1	2	3	4	5	6	7
2.	Threatened to hit or throw something at a family member	0	1	2	3	4	5	6	7
3.	Threw something at family member	0	1	2	3	4	5	6	7
4.	Pushed, grabbed, or shoved a family member	0	1	2	3	4	5	6	7
5.	Hit (or tried to hit) a family member but *not* with anything hard	0	1	2	3	4	5	6	7
6.	Hit (or tried to hit) a family member with something hard	0	1	2	3	4	5	6	7

The next section will focus on behavior of the child with the presenting problem in therapy.
Please rate the degree to which your child has experienced the following problems in the past **30 days**.

	Not at All	*Once or Twice*	*Several Times*	*Often*	*Most of the Time*	*All of the Time*
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

Rate the degree to which your child's problems affect his or her current ability in activities. Consider your child's level of functioning.

	Extreme Troubles	*Quite a few Troubles*	*Some Troubles*	*OK*	*Doing Very Well*
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

Please indicate the extent to which the statement describes **your family** right now.

	Describes us…	*very well*	*well*	*partly*	*not well*	*not at all*
1. In my family we talk to each other about things which matter to us		1	2	3	4	5
2. People often don't tell each other the truth in my family		1	2	3	4	5
3. Each of us gets listened to in our family		1	2	3	4	5

4.	It feels risky to disagree in our family	1	2	3	4	5
5.	We find it hard to deal with everyday problems	1	2	3	4	5
6.	We trust each other	1	2	3	4	5
7.	It feels miserable in our family	1	2	3	4	5
8.	When people in my family get angry they ignore each other on purpose	1	2	3	4	5
9.	We seem to go from one crisis to another in my family	1	2	3	4	5
10.	When one of us is upset they get looked after within the family	1	2	3	4	5
11.	Things always seem to go wrong for my family	1	2	3	4	5
12.	People in the family are nasty to each other	1	2	3	4	5
13.	People in my family interfere too much in each other's lives	1	2	3	4	5
14.	In my family we blame each other when things go wrong	1	2	3	4	5
15.	We are good at finding new ways to deal with things that are difficult	1	2	3	4	5

The next section will focus on health and sleep. Would you be willing to report your: **Weight**: _____

1. Circle the best answer. In general, would you say your health is *Excellent* *Very Good* *Good* *Fair* *Poor*

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? Circle the best answer.
   a. Moderate activities, (e.g. moving a table, vacuuming, or golf) *Yes, limited a lot* *Yes, limited a little* *No, not at all*
   b. Climbing several flights of stairs *Yes, limited a lot* *Yes, limited a little* *No, not at all*

3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health (such as feeling depressed or anxious)?
   a. Accomplished less than you would like *Yes* *No*
   b. Were limited in the kind of work or other activities *Yes* *No*

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
   a. Accomplished less than you would like *Yes* *No*
   b. Did work or other activities less carefully than usual *Yes* *No*

5. During the past 4 weeks, how much did pain interfere with your normal work (including both housework and outside the home)?
   Not at All *A Little Bit* *Moderately* *Quite a Bit* *Extremely*

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.
   How much of the time during the past 4 weeks

		All of the Time	*Most of the Time*	*A Good Bit of the Time*	*Some of the Time*	*A Little of the Time*	*None of the Time*
a.	Have you felt calm and peaceful?	1	2	3	4	5	6
b.	Did you have a lot of energy?	1	2	3	4	5	6
c.	Have you felt downhearted and blue?	1	2	3	4	5	6

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)? Circle the best answer.
   All of the Time *Most of the Time* *Some of the Time* *A Little of the Time* *None of the Time*

8. During the last month how many times have **you** visited medical providers such as primary care or family doctors, internists, surgeons or medical specialists, physicians assistants or medical nurse practitioners as an outpatient?_____

9. During the last month how many nights have **you** stayed in a hospital? _____

10. Do **you** have health insurance? Circle the best answer. *NO* *YES*

Please Answer for you **CHILD in CRISIS (circle the best answers for the PAST 4 WEEKS)**

1. In general, would you say your Child's Health is: *Excellent* *Very Good* *Good* *Fair* *Poor*

2. Has your child been limited in any of the following activities due to HEALTH problems:
   a. Doing things that take some energy such as riding a bike or skating *Yes, limited a lot* *Yes, Limited Some* *Yes, limited a little* *No, not at all*
   b. Bending, lifting, or stooping? *Yes, limited a lot* *Yes, Limited Some* *Yes, limited a little* *No, not at all*

3. Has your child been limited in the KIND of schoolwork or activities with friends he/she could do because of PHYSICAL health?
   Yes, limited a lot *Yes, Limited Some* *Yes, limited a little* *No, not at all*

4. Has your child been limited in the KIND of schoolwork or activities with friends he/she could do
   Yes, limited a lot *Yes, Limited Some* *Yes, limited a little* *No, not at all*

5. How much bodily pain or discomfort has your child had?
   None *Very Mild* *Mild* *Moderate* *Severe* *Very Severe*

6. How satisfied do you think your child has felt about his/her friendships?
   Very satisfied *Somewhat satisfied* *Neither satisfied Nor dissatisfied* *Somewhat dissatisfied* *Very dissatisfied*

7. How satisfied do you think your child has felt about his/her life overall?
   Very satisfied *Somewhat satisfied* *Neither satisfied Nor dissatisfied* *Somewhat dissatisfied* *Very dissatisfied*

8. How much of the time do you think your child acted bothered or upset?
   All of the time *Most of the time* *Some of the time* *A little of the time* *None of the time*

9. Compared to other children your child's age, in general would you say his/her behavior is:
   Excellent *Very good* *Good* *Fair* *Poor*

How often during the past 4 weeks did you…	*All of the Time*	*Most of the Time*	*Some of the Time*	*A Little of the Time*	*None of the Time*
1. Get enough sleep to feel rested upon waking in the morning?	1	2	3	4	5
2. Awaken short breath or with a headache?	1	2	3	4	5
3. Have trouble falling asleep?	1	2	3	4	5
4. Awaken during your sleep time and have trouble falling asleep?	1	2	3	4	5
5. Have trouble staying awake during the day?	1	2	3	4	5
6. Get the amount of sleep you needed?	1	2	3	4	5

If you are in an adult relationship, please complete the following section.

1. Please indicate the degree of happiness, all things considered, of your relationship. Circle the best answer.

Extremely Unhappy	*Fairly Unhappy*	*A Little Unhappy*	*Happy*	*Very Happy*	*Extremely Happy*	*Perfect*
0	1	2	3	4	5	6

	Not at All True	*A Little True*	*Somewhat True*	*Mostly True*	*Completely True*	*Completely True*
2. I have a warm and comfortable relationship with my partner	0	1	2	3	4	5
3. How rewarding is your relationship with your partner?	0	1	2	3	4	5
4. In general, how satisfied are you with your relationship?	0	1	2	3	4	5

Over the past 4 weeks, **how satisfied have you been**:	*Very Dissatisfied*	*Moderately Dissatisfied*	*Equally Satisfied/ Dissatisfied*	*Moderately Satisfied*	*Very Satisfied*
1. With the amount of emotional closeness during sexual activity between you and your partner?	1	2	3	4	5
2. With your sexual relationship with your partner?	1	2	3	4	5
3. How satisfied have you been with your overall sexual life?	1	2	3	4	5