

Therapist ID:

Sex:

Session #:

Client #:

Name:

AUBURN UNIVERSITY MARRIAGE AND FAMILY THERAPY CLINIC

Individual Adult Follow-up

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

	<i>All the Time</i>	<i>Most Times</i>	<i>More than Half the Time</i>	<i>Less than Half the Time</i>	<i>Some-times</i>	<i>At No Time</i>
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

	<i>Not at All</i>	<i>Several Days</i>	<i>More than Half the Days</i>	<i>Nearly Every Day</i>
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

	<i>Not Difficult</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
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

The next section will focus on change.

Please indicate the extent to which you tend to agree or disagree with each statement as a description of you right now.

	<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>
1. I am doing something about the problems that have been bothering me	1	2	3	4	5
2. I am really working hard to change	1	2	3	4	5
3. I wish I had more ideas on how to solve the problem	1	2	3	4	5
4. I have started working on my problems but I would like help	1	2	3	4	5
5. Maybe this place will be able to help me	1	2	3	4	5
6. I may be part of the problems, but I don't really think I am	1	2	3	4	5
7. I hope that someone here will have some good advice for me	1	2	3	4	5
8. Anyone can talk about changing; I'm actually doing something about it	1	2	3	4	5
9. All this talk about psychology is boring. Why can't people just forget about their problems?	1	2	3	4	5
10. I have worries but so does the next guy. Why spend time thinking about them?	1	2	3	4	5
11. I am actively working on my problem	1	2	3	4	5

12. I would rather cope with my faults than try to change them 1 2 3 4 5

The next section will focus on the stress, sexuality, health, sleep.

The questions in this scale ask you about your **feelings and thoughts** during the last month.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
1. How often have you been upset because of something that happened unexpectedly?.....	0	1	2	3	4
2. How often have you felt that you were unable to control the important things in your life?.....	0	1	2	3	4
3. How often have you felt nervous and "stressed"?	0	1	2	3	4
4. How often have you felt confident about your ability to handle your personal problems?.....	0	1	2	3	4
5. How often have you felt that things were going your way?	0	1	2	3	4
6. How often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
7. How often have you been able to control irritations in your life?	0	1	2	3	4
8. How often have you felt that you were on top of things?.....	0	1	2	3	4
9. How often have you been angered because of things that were outside of your control?.....	0	1	2	3	4
10. How often have you felt difficulties were piling up so high that you could not overcome them?.....	0	1	2	3	4

How often have you experienced the following symptoms over the last two months? Never-----Often

1. Sexual problems.....	0	1	2	3
2. Low sex drive	0	1	2	3
3. Sexual over-activity	0	1	2	3
4. Not feeling satisfied with your sex life.....	0	1	2	3
5. Having sex that you didn't enjoy.....	0	1	2	3
6. Bad thoughts or feelings during sex	0	1	2	3
7. Being Confused about your sexual feelings	0	1	2	3
8. Sexual feelings when you shouldn't have them	0	1	2	3

Would you be willing to report your: **Weight:** _____

- Circle the best answer. In general, would you say your health is *Excellent* *Very Good* *Good* *Fair* *Poor*
- 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.
 - Moderate activities, (e.g. moving a table, vacuuming, or golf) *Yes, limited a lot* *Yes, limited a little* *No, not at all*
 - Climbing several flights of stairs *Yes, limited a lot* *Yes, limited a little* *No, not at all*
- 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)?
 - Accomplished less than you would like *Yes* *No*
 - Were limited in the kind of work or other activities *Yes* *No*
- 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)?
 - Accomplished less than you would like *Yes* *No*
 - Did work or other activities less carefully than usual *Yes* *No*
- During the past 4 weeks, how much did pain interfere with your normal work (including both housework and work outside the home)? Circle the best answer.

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...

	<i>All of the Time</i>	<i>Most of the Time</i>	<i>A Good Bit of the Time</i>	<i>Some of the Time</i>	<i>A Little of the Time</i>	<i>None of the Time</i>
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

How often during the past 4 weeks did you...

	<i>All of the Time</i>	<i>Most of the Time</i>	<i>Some of the Time</i>	<i>A Little of the Time</i>	<i>None of the Time</i>
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