DASS21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Alcohol Use Disorders Identification Test Screening Instrument
Just √ the answer that is correct for you

1. How often do you have a drink containing alcohol?

   - [ ] never (0)
   - [ ] monthly or less (1)
   - [ ] two or four times/month (2)
   - [ ] two or three times/week (3)
   - [ ] four or more times/week (4)

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

   - [ ] 1 or 2 (0)
   - [ ] 3 or 4 (1)
   - [ ] 5 or 6 (2)
   - [ ] 7-9 (3)
   - [ ] 10 or more (4)

3. How often do you have six or more drinks on one occasion?

   - [ ] never (0)
   - [ ] less than monthly (1)
   - [ ] monthly (2)
   - [ ] weekly (3)
   - [ ] daily or almost daily (4)

4. How often during the last year have you found that you were not able to stop drinking once you started?

   - [ ] never (0)
   - [ ] less than monthly (1)
   - [ ] monthly (2)
   - [ ] weekly (3)
   - [ ] daily or almost daily (4)

5. How often during the last year have you failed to do what is normally expected from you because of drinking (e.g., missed deadlines, poor classroom or work attendance, failed committee responsibilities, inconsistent work patterns)?

   - [ ] never (0)
   - [ ] less than monthly (1)
   - [ ] monthly (2)
   - [ ] weekly (3)
   - [ ] daily or almost daily (4)

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

   - [ ] never (0)
   - [ ] less than monthly (1)
   - [ ] monthly (2)
   - [ ] weekly (3)
   - [ ] daily or almost daily (4)

7. How often during the past year have you had feelings of guilt or remorse after drinking?

   - [ ] never (0)
   - [ ] less than monthly (1)
   - [ ] monthly (2)
   - [ ] weekly (3)
   - [ ] daily or almost daily (4)

8. How often during the past year have you been unable to remember what happened the night before because you had been drinking?

   - [ ] never (0)
   - [ ] less than monthly (1)
   - [ ] monthly (2)
   - [ ] weekly (3)
   - [ ] daily or almost daily (4)

9. Have you or someone else been injured as a result of your drinking?

   - [ ] no (0)
   - [ ] yes, but not in the last year (2)
   - [ ] yes, during last year (4)

10. Has a relative or friend or doctor or other health worker been concerned about your drinking or suggested you cut down?

    - [ ] no (0)
    - [ ] yes, but not in the last year (2)
    - [ ] yes, during last year (4)

– THIS DOES NOT APPLY TO ALCOHOL –

During the past 12 months…

Circle your response.

1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Have you abused prescription drugs?	Yes	No
3. Did you abuse more than one drug at a time?	Yes	No
4. Could you get through the week without using drugs?	Yes	No
5. Have you always able to stop using drugs when you want to?	Yes	No
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
7. Did you ever feel bad or guilty about your drug use?	Yes	No
8. Did your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10. Have you lost friends because of your use of drugs?	Yes	No
11. Have you neglected your family because of your use of drugs?	Yes	No
12. Have you been in trouble at work because of drug abuse?	Yes	No
13. Have you lost a job because of drug abuse?	Yes	No
14. Have you gotten into fights when under the influence of drugs?	Yes	No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16. Have you been arrested for possession of illegal drugs?	Yes	No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19. Have you gone to anyone for help for a drug problem?	Yes	No
20. Have you been involved in a treatment program specifically related to drug use?	Yes	No

Psychiatric Research Unit
WHO Collaborating Centre in Mental Health

Major (IDC-10) Depression Inventory

The following questions ask about how you have been feeling over the last two weeks. Please put a tick in the box which is closest to how you have been feeling.

	In the last two weeks…						
		All the time	Most of the time	Slightly more than half the time	Slightly less than half the time	Some of the time	At no time
1	How often have you felt low in spirits or sad?	☐	☐	☐	☐	☐	☐
2	How often have you lost interest in your daily activities?	☐	☐	☐	☐	☐	☐
3	How often have you felt lacking in energy and strength?	☐	☐	☐	☐	☐	☐
4	How often have you felt less self-confident?	☐	☐	☐	☐	☐	☐
5	How often have you had a bad conscience or feelings of guilt?	☐	☐	☐	☐	☐	☐
6	How often have you felt that life wasn't worth living?	☐	☐	☐	☐	☐	☐
7	How often have you had difficulty in concentrating, e.g. when reading the newspaper or watching television?	☐	☐	☐	☐	☐	☐
8a	How often have you felt very restless?	☐	☐	☐	☐	☐	☐
8b	How often have you felt subdued or slowed down?	☐	☐	☐	☐	☐	☐
9	How often have you had trouble sleeping at night?	☐	☐	☐	☐	☐	☐
10a	How often have you suffered from a reduced appetite?	☐	☐	☐	☐	☐	☐
10b	How often have you suffered from an increased appetite?	☐	☐	☐	☐	☐	☐

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Meaning in Life Questionnaire

Please take a moment to think about what makes your life and existence feel important and significant to you. Please respond to the following statements as truthfully and accurately as you can, and also please remember that these are very subjective questions and that there are no right or wrong answers. Select how true or untrue each statement is for you.

	Absolutely Untrue	Mostly Untrue	Somewhat Untrue	Can't Say True or False	Somewhat True	Mostly True	Absolutely True
1. I understand my life's meaning.	☐	☐	☐	☐	☐	☐	☐
2. I am looking for something that makes my life feel meaningful.	☐	☐	☐	☐	☐	☐	☐
3. I am always looking to find my life's purpose.	☐	☐	☐	☐	☐	☐	☐
4. My life has a clear sense of purpose.	☐	☐	☐	☐	☐	☐	☐
5. I have a good sense of what makes my life meaningful.	☐	☐	☐	☐	☐	☐	☐
6. I have discovered a satisfying life purpose.	☐	☐	☐	☐	☐	☐	☐
7. I am always searching for something that makes my life feel significant.	☐	☐	☐	☐	☐	☐	☐
8. I am seeking a purpose or mission for my life.	☐	☐	☐	☐	☐	☐	☐
9. My life has no clear purpose.	☐	☐	☐	☐	☐	☐	☐
10. I am searching for meaning in my life.	☐	☐	☐	☐	☐	☐	☐

Satisfaction with Life Scale

Below are statements that you may agree or disagree with. Read each one and then indicate the words that best reflect your feelings about your life at this time.

	NOT AT ALL	VERY LITTLE	AVERAGE	OK	A LOT - GREAT
1. How much do you like the place where you live? (today)	0	1	2	3	4
2. How satisfied are you with the amount of privacy you have in your current living situation?	0	1	2	3	4
3. How satisfied are you with the amount of space you have in your current living situation?	0	1	2	3	4
4. How much do you like the food you usually eat?	0	1	2	3	4
5. How satisfied are you with the way you spend your evenings and weekends?	0	1	2	3	4
6. How satisfied are you with the number of friends you have?	0	1	2	3	4
7. Do you feel as close to your friends as you would like to be?	0	1	2	3	4
8. How satisfied are you with the kind and amount of contact you have with the opposite sex?	0	1	2	3	4
9. How satisfied are you with your current social life?	0	1	2	3	4
10. How satisfied are you with the kinds of relationships you have with the members of your family?	0	1	2	3	4
11. How satisfied are you with the way you spend your days?	0	1	2	3	4
12. How satisfied are you with the kind of work that you do?	0	1	2	3	4
13. Do you feel that you are working as much as you would like?	0	1	2	3	4
14. How satisfied are you with your current psychological condition?	0	1	2	3	4
15. How satisfied are you with your present life?	0	1	2	3	4
16. How satisfied are you with yourself on the whole?	0	1	2	3	4
17. Do you feel you get as much enjoyment from life as most people do?	0	1	2	3	4
18. Do you feel that you have as much freedom as you want?	0	1	2	3	4

For scoring Purposes Only:	
Living Situation (4)	
Social Relationships (6)	
Employment/Work (2)	
Self and Present Life (6)	

TREATMENT GOALS ASSESSMENT

The following is a list of goals that people coming to treatment sometimes have. Please put and **X** in the box beside any of goals that apply to you at the present. When you have done that, indicate in the next column any goal that you think you need help to achieve.

	This is one of my present goals	I need help to achieve this goal
1. To deal with my alcohol and/or drug use.	☐	☐
2. To learn to be less tense or anxious.	☐	☐
3. To learn to stand up for my rights better and to be able to express good or bad feelings directly.	☐	☐
4. To improve my relationship with others (spouse/partner, girlfriend/boyfriend, children, parents, etc.).	☐	☐
5. To be able to get along better socially.	☐	☐
6. To improve my ability to find and keep a job.	☐	☐
7. To learn to use my leisure time better.	☐	☐
8. To improve the nature of my living arrangements.	☐	☐
9. To deal effectively with legal problems that at the present confront me.	☐	☐
10. To deal effectively with financial problems that at the present confront me.	☐	☐
11. To increase my understanding of sexual problems and sexual behavior.	☐	☐

SUMMARY

How many goals have you indicated? ___________________

Of the goals you indicated, which are the most important for you to solve at the moment?

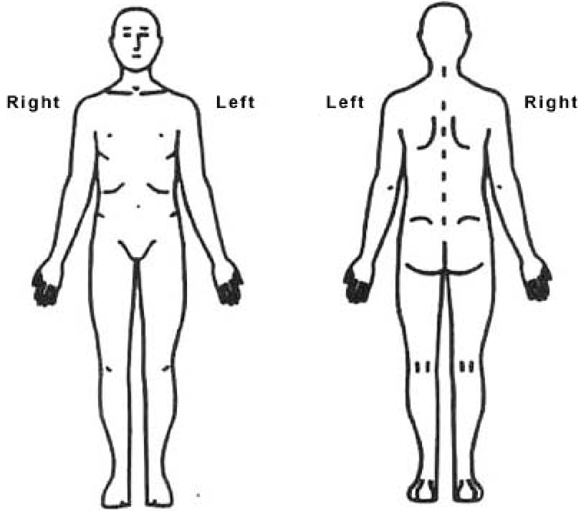
My first most important goal is # __________
My second most important goal is # __________
My third most important goal is # __________
My fourth most important goal is # __________

Brief Pain Inventory

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain, other than these everyday kinds of pain, today?

☐ yes ☐ no

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its least in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the average.

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now.

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?

8. In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the percentage that most shows how much.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No relief — Complete

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

a. General Activity:

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

b. Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

c. Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

d. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

e. Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

f. Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

g. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes