NAME	DATE

Ethnicity *and/or Nationality*: _____

Gender: female/ male/ others, pls specify: _____

Sexual Orientation: heterosexual/ lesbian/ gay/ bisexual/ prefer not to say/ other, pls specify: _____

Relationship status: single/ married or civil partnered/ prefer not to say/ other, pls specify: _____

Education achieved: _____Main occupation: _____

Family members living together in your household

_____

_____

Please describe the main problem/challenge that you are facing (with time specified)

_____

_____

_____

_____

How severe is it? Please mark your answer on the line below:

no problem at all **really bad**

0 1 2 3 4 5 6 7 8 9 10

How are you managing the problem/challenge together with the significant people in your life?

Very well **very badly**

0 1 2 3 4 5 6 7 8 9 10

Do you think the therapy here will be / has been helpful?

Very helpful **unhelpful**

0 1 2 3 4 5 6 7 8 9 10

List the significant people in your life now whom you will be thinking of when answering the following section of the questionnaire *(such as partner, friend age 22, etc, no name please)*.

_____

_____

What words would best describe these relationships at present?

_____

_____

Which is/are the most significant role(s) you play in your current significant relationships? *eg. partner, parent, etc*

_____

_____

We would like you to tell us *how well the 15 items below describe YOUR CURRENT view* of the significant relationships you listed above. For each item, make your choice by circling the box numbered 1 to 5. If a statement is "We are nasty to each other" and you feel this is not especially true of your relationships, circle 5 for "Not at all". Do not think for too long about any question, but do try to circle one of the boxes for each question.

For each line, would you say **this describes your significant relationships:**	**Describe us**				
	Very Well	**Well**	**Partly**	**Not well**	**Not at all**
1) We talk to each other about things which matter to us	1	2	3	4	5
2) We often don't tell each other the truth	1	2	3	4	5
3) Each of us gets listened to by the other(s)	1	2	3	4	5
4) It feels risky to disagree in our relationship(s)	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 relationship(s)	1	2	3	4	5
8) When we get angry we ignore each other on purpose	1	2	3	4	5
9) We seem to go from one crisis to another	1	2	3	4	5
10) When one of us is upset we get looked after by the other(s)	1	2	3	4	5
11) Things always seem to go wrong for us	1	2	3	4	5
12) We are nasty to each other	1	2	3	4	5
13) We interfere too much in each other's lives	1	2	3	4	5
14) 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

What words would best describe your family (or your relationship)?

_____

_____

_____

RDAS-Revised Dyadic Adjustment Scale

Most people have disagreements in their relationships. Please indicate below the extent of agreement or disagreement between you and your partner for each item.

	Always Agree	Almost Always Agree	Occasionally Agree	Frequently Disagree	Almost Always Disagree	Always Disagree
Religious matters						
Demonstrations of affection						
Making major decisions						
Sex relations						
Conventionality (correct or proper behaviour)						
Career decisions						
Living arrangement						
Involvement of in-law						
Parenting						

	All the Time	Most of the time	More often than not	Occasionally	Rarely	Never
How often do you discuss, or have you considered divorce, separation, or terminating your relationship?						
How often do you and your partner quarrel?						
Do you ever regret that you married (or lived together)?						
How often do you and your partner "get on each other's nerves"?						
How often does physical violence happen between you and your partner?						

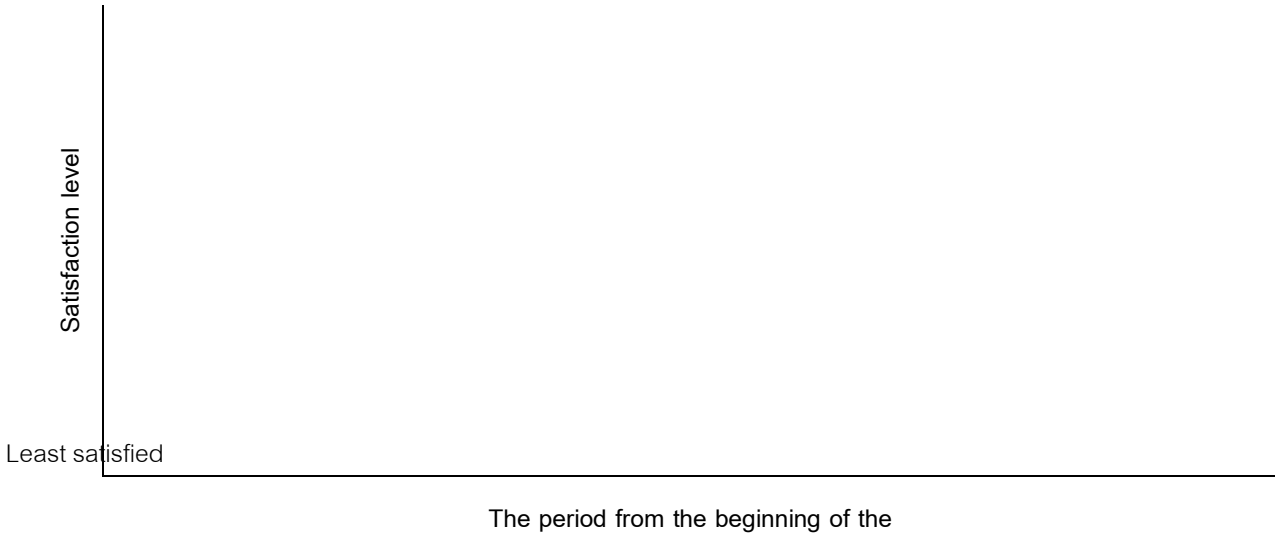
How often would you say the following events occur between you and your partner?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
Engage in outside interests together?						
Have a stimulating exchange of ideas						
Work together on a project						
Calmly discuss something						

For each of the following items, select the answer that best describes *how you feel about your relationship.* Base your responses on your first impressions and immediate feelings about the item.

INTERESTING	5	4	3	2	1	0	BORING
BAD	0	1	2	3	4	5	GOOD
FULL	5	4	3	2	1	0	EMPTY
LONELY	0	1	2	3	4	5	FRIENDLY
STURDY	5	4	3	2	1	0	FRAGILE
DISCOURAGING	0	1	2	3	4	5	HOPEFUL
ENJOYABLE	5	4	3	2	1	0	MISERABLE

Please draw a graph that indicates your level of satisfaction in your relationship, starting with when you meet your partner. Notice any important/significant events in your relationship (e.g., one of you moved out, one of you cheated on you).



You have undergone couple therapy.

☐ no ☐ Yes (please specify the duration_____)

Outcome from therapy ☐ significantly improved ☐ Somewhat better

☐ Same as before☐ Somewhat worse. ☐ much worse.

Your hopes for this couple therapy

1. _____

2. _____

3. _____

THANK YOU FOR YOUR TIME

GAD-7 Anxiety

Over the last two weeks, 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	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

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety 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	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

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 _____

Name:_____ Date: _____

Pittsburgh Sleep Quality Index (PSQI)

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. **Please answer all questions.**

1. During the past month, what time have you usually gone to bed at night? _____
2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night? _____
3. During the past month, what time have you usually gotten up in the morning? _____
4. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.) _____

5. During the past month, how often have you had trouble sleeping because you…	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
a. Cannot get to sleep within 30 minutes				
b. Wake up in the middle of the night or early morning				
c. Have to get up to use the bathroom				
d. Cannot breathe comfortably				
e. Cough or snore loudly				
f. Feel too cold				
g. Feel too hot				
h. Have bad dreams				
i. Have pain				
j. Other reason(s), please describe:				
6. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?				
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
	No problem at all	Only a very slight problem	Somewhat of a problem	A very big problem
8. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?				
	Very good	Fairly good	Fairly bad	Very bad
9. During the past month, how would you rate your sleep quality overall?				

	No bed partner or room mate	Partner/room mate in other room	Partner in same room but not same bed	Partner in same bed
10. Do you have a bed partner or room mate?				
	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
If you have a room mate or bed partner, ask him/her how often in the past month you have had:				
a. Loud snoring				
b. Long pauses between breaths while asleep				
c. Legs twitching or jerking while you sleep				
d. Episodes of disorientation or confusion during sleep				
e. Other restlessness while you sleep, please describe:				

This questionnaire is intended for clients attending mental health service with Dr. Pantri, to support understanding and treatment planning. The questionnaire has four sections. You can choose to answer the sections that you think are relevant if the time is limited. Thank you very much.

Substance Questionnaire

Drugs and drugs used in the last 3 months (more than 1 answer)

☐ Cigarette ☐ E-cigarette ☐ Alcohol ☐ Marijuana ☐ amphetamine ☐ Ice

☐ Ecstasy ☐ LSD ☐ Volatile agents ☐ Heroin ☐ Tramadol

☐ benzodiazepine ☐ Others .....

The main drugs or narcotic substances used during the last 3 months are.....

Drugs or drugs used in the last 3 months And the screens in this table are.....	never	Only 1-2 times	1-3 times a month	1-4 times a week	nearly Every day
How often do you use .....?	0	2	3	4	6
How often do you have unbearable desires or feelings of wanting to use .....?	0	1	2	3	6
How often does using ..... cause you health, family, social, legal, or financial problems?	0	1	2	3	7
How often does using ..... prevent you from taking responsibility or doing activities that you used to normally do?	0	1	2	3	8

In recent times	never	Yes, but 3 months ago	Yes in the past 3 months
Relatives, friends, or acquaintances have admonished, criticized, faulted, or expressed suspicion that you are related to	0	3	6
Have you ever reduced or stopped using ..... but were unsuccessful?	0	3	6

(2-3 mild; 5-26 moderate; 27 severe)

Have you ever used injectable drugs? ☐ yes ☐ no

Do you drink alcohol almost every day? ☐ yes ☐ no

Do you smoke almost daily? ☐ yes ☐ no