Please circle the most accurate answer under each statement:

1. I believe that my mother loved me when I was little.

Definitely true Probably true Not sure Probably Not True Definitely Not True

2. I believe that my father loved me when I was little.

Definitely true Probably true Not sure Probably Not True Definitely Not True

3. When I was little, other people helped my mother and father take care of me and they seemed to love me.

Definitely true Probably true Not sure Probably Not True Definitely Not True

4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.

Definitely true Probably true Not sure Probably Not True Definitely Not True

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.

Definitely true Probably true Not sure Probably Not True Definitely Not True

6. When I was a child, neighbors or my friends' parents seemed to like me.

Definitely true Probably true Not sure Probably Not True Definitely Not True

7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.

Definitely true Probably true Not sure Probably Not True Definitely Not True

8. Someone in my family cared about how I was doing in school.

Definitely true Probably true Not sure Probably Not True Definitely Not True

9. My family, neighbors and friends talked often about making our lives better.

Definitely true Probably true Not sure Probably Not True Definitely Not True

10. We had rules in our house and were expected to keep them.

Definitely true Probably true Not sure Probably Not True Definitely Not True

11. When I felt really bad, I could almost always find someone I trusted to talk to.

Definitely true Probably true Not sure Probably Not True Definitely Not True

12. As a youth, people noticed that I was capable and could get things done.

Definitely true Probably true Not sure Probably Not True Definitely Not True

13. I was independent and a go-getter.

Definitely true Probably true Not sure Probably Not True Definitely Not True

14. I believed that life is what you make it.

Definitely true Probably true Not sure Probably Not True Definitely Not True

How many of these 14 protective factors did I have as a child and youth? (How many of the 14 were circled "Definitely True" or "Probably True"?) _____

Of these circled, how many are still true for me? _____

ADVERSE CHILDHOOD EXPERIENCE QUESTIONNAIRE

PRIOR TO YOUR 18TH BIRTHDAY:

	QUESTION	NO	YES
1.	DID A PARENT OR OTHER ADULT IN THE HOUSEHOLD OFTEN OR VERY OFTEN... SWEAR AT YOU, INSULT YOU, PUT YOU DOWN, OR HUMILIATE YOU? OR ACT IN A WAY THAT MADE YOU AFRAID THAT YOU MIGHT BE PHYSICALLY HURT?		
2.	DID A PARENT OR OTHER ADULT IN THE HOUSEHOLD OFTEN OR VERY OFTEN... PUSH, GRAB, SLAP OR THROW SOMETHING AT YOU? OR EVEN HIT YOU SO HARD THAT YOU HAD MARKS OR WERE INJURED?		
3.	DID AN ADULT OR PERSON AT LEAST 5 YEARS OLDER THAN YOU EVER... TOUCH OR FONDLE YOU OR HAVE YOU TOUCH THEIR BODY IN A SEXUAL WAY? OR ATTEMPT TO ACTUALLY HAVE ORAL, ANAL, OR VAGINAL INTERCOURSE WITH YOU?		
4.	DID YOU OFTEN OR VERY OFTEN FEEL THAT... NO ONE IF YOUR FAMILY LOVED YOU OR THOUGHT YOU WERE IMPORTANT OR SPECIAL? OR YOUR FAMILY DIDN'T LOOK OUT FOR EACH OTHER, FEEL CLOSE TO EACH OTHER, OR SUPPORT EACH OTHER?		
5.	DID YOU OFTEN OR VERY OFTEN FEEL THAT... YOU DIDN'T HAVE ENOUGH TO EAT, HAD TO WEAR DIRTY CLOTHES, AND HAD NO ONE TO PROTECT YOU? OR YOUR PARENTS WERE TOO DRUNK OR HIGH TO TAKE CARE OF YOU OR TAKE YOU TO THE DOCTOR IF YOU NEEDED IT?		
6.	WERE YOUR PARENTS EVER SEPARATED OR DIVORCED?		
7.	WAS YOUR MOTHER OR STEPMOTHER: OFTEN OR VERY OFTEN PUSHED, GRABBED, SLAPPED, OR HAD SOMETHING THROWN AT HER? OR SOMETIMES, OFTEN, OR VERY OFTEN KICKED, BITTEN, HIT WITH A FIST OR HIT WITH SOMETHING HARD? OR EVER REPEATEDLY HIT OVER AT LEAST A FEW MINUTES OR THREATENED WITH A GUN OR KNIFE?		
8.	DID YOU LIVE WITH ANY ONE WHO WAS A PROBLEM DRINKER OR ALCOHOLIC, OR WHO USED STREET DRUGS?		
9.	WAS A HOUSEHOLD MEMBER DEPRESSED OR MENTALLY ILL, OR DID A HOUSEHOLD MEMBER ATTEMPT SUICIDE?		
10.	DID A HOUSEHOLD MEMBER GO TO PRISON?		
11.	NOW ADD UP YOUR "YES" ANSWERS: _____ THIS IS YOUR ACE SCORE		

C-SSRS Self-Report - Recent

Please place a check mark in the box for the appropriate answers	In the past Month	
Please answer questions 1 and 2	**Y**	**N**
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts of killing yourself? **If YES, answer all questions 3, 4, 5, and 6.** **If NO, skip directly to question 6.**		
3) Have you thought about how you might do this? *(For example, "I thought about taking an overdose but I never worked out the details about when, where, and how I would do that and I would never act on these thoughts.")*		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts, but you definitely would not act on them? *(For example, "I had the thought of killing myself by taking an overdose and am not sure whether I would do it or not.")*		
5) Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you actually intend to carry out the details of your plan? *(For example, "I am planning to take 3 bottles of my sleep medication this Saturday when no one is around to stop me.")*		
6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? *(For example: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind about hurting yourself or it was grabbed from your hand, went to the roof to jump but didn't, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note; etc.)*		
If YES, did this occur in the past 3 months? OR in your lifetime? **If YES, what did you do?** _____ _____ _____		

Generalized Anxiety Disorder 7-Item (GAD-7) Scale

Name: Click here to enter text. **Date:** Click here to enter text.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not At All	Several Days	Over 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's 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
Add Scores for Each Column	☐ +	☐ +	☐ +	☐
Total Score (Sum of Column Scores)				

If any of the above problems were identified, how difficult have these 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**

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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
☐	☐	☐	☐