People's Care
BEHAVIORAL HEALTH

Clinical Client Questionnaire

During the past **TWO WEEKS** how much or how often have you been bothered by the following problems	NONE Not at all	SLIGHT Rare, less than a day or to	MILD Several days	MODERATE More than half the days	SEVERE Nearly every day
Little interest or pleasure in doing things?	____0	_____1	_____2	_____3	_____4
Feeling more irritated, grouchy or more angry than usual?	____0	_____1	_____2	_____3	_____4
Sleeping less than usual, but still having a lot of energy?	____0	_____1	_____2	_____3	_____4
Starting more projects than usual or doing more risky things than usual?	____0	_____1	_____2	_____3	_____4
Feeling nervous anxious, worried, frightened or on edge?	____0	_____1	_____2	_____3	_____4
Feeling panic or being frightened	____0	_____1	_____2	_____3	_____4
Avoiding situations that make you anxious?	____0	_____1	_____2	_____3	_____4
Unexplainable aches and pains (e.g., head, back, joints, abdomen, legs)?	____0	_____1	_____2	_____3	_____4
Feeling that your illnesses are not being taken seriously enough?	____0	_____1	_____2	_____3	_____4
Thoughts of actually hurting yourself?	____0	_____1	_____2	_____3	_____4
Hearing things other people couldn't hear such as voices, even when no one was around?	____0	_____1	_____2	_____3	_____4
Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	____0	_____1	_____2	_____3	_____4

Problems with sleep affecting your sleep quality overall?	____0	_____1	_____2	_____3	_____4
Problems with memory (e.g. learning new information) or with location (finding your way home).	____0	_____1	_____2	_____3	_____4
Unpleasant thoughts, urges, or images that repeatedly enter your mind?	____0	_____1	_____2	_____3	_____4
Feeling driven to perform certain behaviors or mental acts over and over again.	____0	_____1	_____2	_____3	_____4
Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	____0	_____1	_____2	_____3	_____4
Not knowing who you really are or what you really want out of life?	____0	_____1	_____2	_____3	_____4
Not feeling close to other people or enjoying your relationships with them?	____0	_____1	_____2	_____3	_____4
Drinking at least 4 drinks a day of any alcoholic beverages?	____0	_____1	_____2	_____3	_____4
Using of any of the following medicines, ON Your Own, that is without a doctor's prescription, in greater amounts or longer than prescribed.	____0	_____1	_____2	_____3	_____4