



IMPORTANT - PLEASE READ THIS FIRST
 This form has 10 statements about how you have been OVER THE LAST WEEK.
 Please read each statement and think how often you felt that way last week.
 Then tick the box which is closest to this.

Over the last week

	<i>Not at all</i>	<i>Only Occasionally</i>	<i>Sometimes</i>	<i>Often</i>	<i>Most or all the time</i>
1 I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2 I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
3 I have felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
4 Talking to people has felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5 I have felt panic or terror	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6 I made plans to end my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7 I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8 I have felt despairing or helpless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9 I have felt unhappy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10 Unwanted images or memories have been distressing me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Total (Clinical Score*)

***Quick scoring if all items completed: add together the item scores to get the Clinical Score.
 It is not recommended to compute a score if more than one item was omitted but if nine were completed:
 add together the item scores, divide by nine to get the mean score, then multiply by 10 to get the Clinical Score.**

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE