Clinician and Patient-Reported Outcome Measures (PROMs)

CONTENTS

BRIEF ADDICTION MONITOR (BAM)

Participant ID: _____ Date: _____

Interviewer ID (Clinician Initials): _____

Instructions:

This is a standard set of questions about several areas of your life such as your health, alcohol. and drug use, etc. The questions generally ask about the past 30 days. Pease consider each question and answer as accurately as possible.

Method of Administration:

☐ Clinician Interview ☐ Self Report ☐ Phone

1. In the past 30 days, how would you say your physical health has been?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

2. In the past 30 days, how many nights did you have trouble falling asleep or staying asleep?

_____

3. In the past 30 days, how many days have you felt depressed, anxious, angry, or very upset throughout most of the day?

_____

4. In the past 30 days, how many days did you drink ANY alcohol?

_____ (If 0, skip to #6)

5. In the past 30 days, how many days did you have at least 5 drinks (if you are a man) or at least 4 drinks (if you are a woman)? [One drink is considered one shot of hard liquor (1.5 oz.) or 12-ounce can/bottle of beer or 5-ounce glass of wine.]

_____

6. In the past 30 days, how many days did you use any illegal or street drug or abuse any prescription medication?

_____ (If 0, skip to #8)

7. In the past 30 days, how many days did you use any of the following drugs:

- ☐ Marijuana (cannabis, pot, weed)?
- ☐ Sedatives and/or Tranquilizers (benzos, Valium, Xanax, Ativan. barbs, Phenobarbital, downers, etc.)?
- ☐ Cocaine and/or Crack?
- ☐ Other Stimulants (amphetamines, methamphetamine, dexedrine, Ritalin, Adderall, speed, crystal meth, ice, etc.)?
- ☐ Opiates (Heroin, Morphine, Dilaudid, Demerol, Oxycontin, oxy, codeine (Tylenol 2,3,4), Percocet, Vicodin, Fentanyl, etc.)?
- ☐ Inhalants (glues, adhesives, nail polish remover, paint thinner, etc.)?
- ☐ Other Drugs (steroids, non-prescription sleep and diet pills, Benadryl, Ephedra, other over-the-counter or unknown medication)?

8. In the past 30 days, how much were you bothered by cravings or urges to drink alcohol or use drugs?

- ☐ Not at all (0)
- ☐ Slightly (8)
- ☐ Moderately (15)
- ☐ Considerably (22)
- ☐ Extremely (30)

9. How confident are you that you will NOT use alcohol and drugs in the next 30 days?

- ☐ Not at all (0)
- ☐ Slightly (8)
- ☐ Moderately (15)
- ☐ Considerably (22)
- ☐ Extremely (30)

10. In the past 30 days, how many days did you attend self-help meetings like AA or NA to support your recovery?

_____

11. In the past 30 days, how many days were you in any situations or with any people that might put you at an increased risk for using alcohol or drugs (i.e., around risky “people, places or things”)?

_____

12. Does your religion or spirituality help support your recovery?

- ☐ Not at all (0)
- ☐ Slightly (8)
- ☐ Moderately (15)
- ☐ Considerably (22)
- ☐ Extremely (30)

13. In the past 30 days, how many days did you spend much of the time at work, school, or doing volunteer work?

_____

14. Do you have enough income (from legal sources) to pay for necessities such as housing, transportation, food and clothing for yourself and your dependents?

- ☐ No (0)
- ☐ Yes (30)

15. In the past 30 days, how much have you been bothered by arguments or problems getting along with any family member or friends?

- ☐ Not at all (0)
- ☐ Slightly (8)
- ☐ Moderately (15)
- ☐ Considerably (22)
- ☐ Extremely (30)

16. In the past 30 days, how many days did you contact or spend time with any family members or friends who are supportive of your recovery?

_____

17. How satisfied are you with your progress toward achieving your recovery goals?

- ☐ Not at all (0)
- ☐ Slightly (8)
- ☐ Moderately (15)
- ☐ Considerably (22)
- ☐ Extremely (30)

TOBACCO, ALCOHOL, PRESCRIPTION MEDICATIONS, AND OTHER SUBSTANCES (TAPS) TOOL

TAPS-1

General Instructions:
The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year. Question 2 should be answered only by males and Question 3 only be females. Each of the four multiple-choice items has five possible responses to choose from.

Segment: _____ Visit Number: _____

1. In the PAST 12 MONTHS, how often have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?

- ☐ Daily or Almost Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less Than Monthly
- ☐ Never

2. In the PAST 12 MONTHS, how often have you had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by males).

- ☐ Daily or Almost Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less Than Monthly
- ☐ Never

3. In the PAST 12 MONTHS, how often have you had 4 or more drinks containing alcohol in one day?One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by females).

- ☐ Daily or Almost Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less Than Monthly
- ☐ Never

4. In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

- ☐ Daily or Almost Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less Than Monthly
- ☐ Never

5. In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you? Prescription medications that may be used this way include: Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medication for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)

- ☐ Daily or Almost Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less Than Monthly
- ☐ Never

TAPS-2

General Instructions:
The TAPS Tool Part 2 is a brief assessment for tobacco, alcohol, and illicit substance use and prescription medication misuse in the PAST 3 MONTHS ONLY. Each of the following questions and subquestions has two possible answer choices- either yes or no. Check the box to select your answer.

1. In the PAST 3 MONTHS, did you smoke a cigarette containing tobacco?

☐ YES ☐ NO

If "YES," answer the following questions:

a. In the PAST 3 MONTHS, did you usually smoke more than 10 cigarettes each day?

☐ YES ☐ NO

b. In the PAST 3 MONTHS, did you usually smoke within 30 minutes after waking?

☐ YES ☐ NO

2. In the PAST 3 MONTHS, did you have a drink containing alcohol?

☐ YES ☐ NO

If "YES," answer the following questions:

a. In the PAST 3 MONTHS, did you have 4 or more drinks containing alcohol in a day? (NOTE: This is a question that should only be answered by females.)

☐ YES ☐ NO

b. In the PAST 3 MONTHS, did you have 5 or more drinks containing alcohol in a day? (NOTE: This question should only be answered by males.)

☐ YES ☐ NO

One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

c. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop drinking?

☐ YES ☐ NO

d. In the PAST 3 MONTHS, has anyone expressed concern about your drinking?

☐ YES ☐ NO

3. In the PAST 3 MONTHS, did you use marijuana (hash, weed)?

☐ YES ☐ NO

If "YES," answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use marijuana at least once a week or more often?

☐ YES ☐ NO

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of marijuana?

☐ YES ☐ NO

4. In the PAST 3 MONTHS, did you use cocaine, crack or methamphetamine (crystal meth)?

☐ YES ☐ NO

If "YES," answer the following questions:

a. In the PAST 3 MONTHS, did you use cocaine, crack at least once a week or more often?

☐ YES ☐ NO

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of cocaine, crack or methamphetamine (crystal meth)?

☐ YES ☐ NO

5. In the PAST 3 MONTHS, did you use heroin?

☐ YES ☐ NO

If "YES," answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down, or stop using heroin?

☐ YES ☐ NO

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of heroin?

☐ YES ☐ NO

6. In the PAST 3 MONTHS, did you use a prescription opiate pain reliever (for example, Percocet, Vicodin) not as prescribed or that was not prescribed to you?

☐ YES ☐ NO

If "YES," answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using an opiate pain reliever?

☐ YES ☐ NO

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of an opiate pain reliever?

☐ YES ☐ NO

7. In the PAST 3 MONTHS, did you use a medication for anxiety or sleep (for example, Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you?

☐ YES ☐ NO

If "YES," answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use medications for anxiety or sleep at least once a week or more often?

☐ YES ☐ NO

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of medication for anxiety or sleep?

☐ YES ☐ NO

8. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) not as prescribed or that was not prescribed for you?

☐ YES ☐ NO

If "YES," answer the following questions:

a. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) at least once a week or more often?

☐ YES ☐ NO

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of medication for ADHD (for example, Adderall or Ritalin)?

☐ YES ☐ NO

9. In the PAST 3 MONTHS, did you use any other illegal or recreational drug (for example, ecstasy/molly, GHB, poppers, LSD, mushrooms, special k, bath salts, synthetic marijuana ('spice'), whip-its, etc.?

☐ YES ☐ NO

If "YES," answer the following questions:

a. In the PAST 3 MONTHS, what were the other dug(s) you used?

Comments: _____

PHENX CIGARETTE SMOKING STATUS

1. Have you ever smoked a cigarette, even one or two puffs?

- ☐ Yes
- ☐ No
- ☐ DON'T KNOW
- ☐ REFUSED

If Question 1 is "Yes," then respondent is asked:

2. Do you now smoke cigarettes...

- ☐ Every day
- ☐ Some days
- ☐ Not at all
- ☐ DON'T KNOW
- ☐ REFUSED

3. How many cigarettes have you smoked in your entire life? A pack usually has 20 cigarettes in it.

- ☐ 1 or more puffs but never a whole cigarette
- ☐ 1 to 10 cigarettes (about ½ pack total)
- ☐ 11 to 20 cigarettes (about ½ pack to 1 pack)
- ☐ 21 to 50 cigarettes (more than 1 pack but less than 3 packs)
- ☐ 51 to 99 cigarettes (more than 2 ½ packs but less than 5 packs)
- ☐ 100 or more cigarettes (5 packs or more)
- ☐ DON'T KNOW
- ☐ REFUSED

If Question 1 is "Yes" and Question 2 is "Some days" (Current Some-Day Smoker) or if Question 1 is "Yes" and Question 2 is "Not at all" (Former Smoker), then respondent is asked:

4. 4. Around this time 12 months ago, were you smoking cigarettes every day, some days, or not at all?

- ☐ Every day
- ☐ Some days
- ☐ Not at all
- ☐ DON'T KNOW
- ☐ REFUSED

PHENX INJECTION DRUG USE

The following questions are about the different ways that certain drugs can be used.

1. Have you ever, even once, used a needle to inject a drug not prescribed by a doctor? Please select . . .

- ☐ Yes
- ☐ No
- ☐ Refused
- ☐ Don't Know

If respondent answers, "No," "Refused," or "Don't Know," the protocol is complete.

2. Which of the following drugs have you injected using a needle? Please select all the drugs that you injected.

- ☐ Cocaine
- ☐ Heroin
- ☐ Methamphetamine
- ☐ Steroids
- ☐ Any other drugs
- ☐ Refused
- ☐ Don't Know

3. How old were you when you first used a needle to inject any drug not prescribed by a doctor? Please enter an age.

_____ ENTER AGE IN YEARS

- ☐ Refused
- ☐ Don't Know

4. How long ago has it been since you last used a needle to inject a drug not prescribed by a doctor? Please enter the number of days, weeks, months, or years, and then select the unit of time.

_____ ENTER NUMBER OF DAYS, WEEKS, MONTHS, OR YEARS

- ☐ Refused
- ☐ Don't Know

ENTER UNIT

- ☐ Days
- ☐ Weeks
- ☐ Months
- ☐ Years

- [ ] Refused
- [ ] [ ] Don't Know

5. During your life, altogether how many times have you injected drugs not prescribed by a doctor? Please enter one of the following choices:

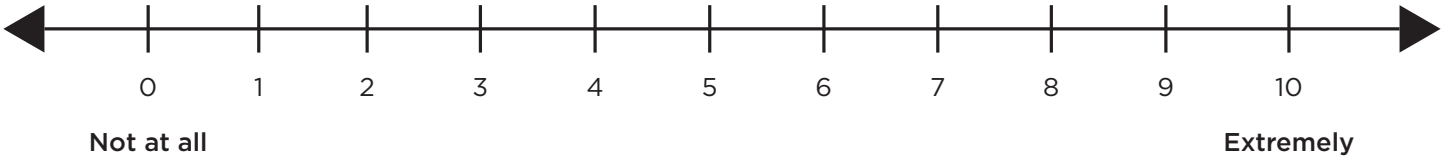
- [ ] Once
- [ ] 2–5 times
- [ ] 6–19 times
- [ ] 20–49 times
- [ ] 50–99 times
- [ ] 100 times or more
- [ ] Refused
- [ ] Don't Know

6. Think about the period of your life when you injected drugs the most often. How often did you inject then? Please select one of the following choices.

- [ ] More than once a day
- [ ] About once a day
- [ ] At least once a week but not every day
- [ ] At least once a month but not every week
- [ ] Less than once a month
- [ ] Refused
- [ ] Don't Know

Visual Analog Scale for Craving(VAS)

Please mark the appropriate area on the line: How much craving are you experiencing in this moment?



SHORT OPIATE WITHDRAWAL SCALE (SOWS)

Please put a check mark in the appropriate box for each of the following condition in the last 24 hrs

1. **Feeling Sick:**
   ☐ None ☐ Mild ☐ Moderate ☐ Severe

2. **Stomach Cramps:**
   ☐ None ☐ Mild ☐ Moderate ☐ Severe

3. **Muscle Spasms/Twitching:**
   ☐ None ☐ Mild ☐ Moderate ☐ Severe

4. **Feelings of Coldness:**
   ☐ None ☐ Mild ☐ Moderate ☐ Severe

5. **Heart Pudding:**
   ☐ None ☐ Mild ☐ Moderate ☐ Severe

6. **Muscular Tension:**
   ☐ None ☐ Mild ☐ Moderate ☐ Severe

7. **Aches and Pains:**
   ☐ None ☐ Mild ☐ Moderate ☐ Severe

8. **Yawning:**
   ☐ None ☐ Mild ☐ Moderate ☐ Severe

9. **Runny Eyes:**
   ☐ None ☐ Mild ☐ Moderate ☐ Severe

10. **Insomnia/Problems Sleeping:**
    ☐ None ☐ Mild ☐ Moderate ☐ Severe

TREATMENT EFFECTIVENESS ASSESSMENT (TEA)

The TEA asks you to express the extent of changes for the better from your involvement in the program to this point (or how things are if it's your first TEA baseline) in four areas: subtsance use, health, lifestyle, and community. For each area, think about how things have become better and circle the results on the scale below: the more you have improved, the higher the number - from 1 (not better at all) to 10 (very much better). In each area write down the last one or two changes most important to you in the Remarks sections. Feel free to use the back of this page to add details, explain remarks, and make comments.

Substance use: How much better are you with drug and alcohol use? Consider the frequency and amount of use, money spent on drugs, amount of drug craving, time spent being loaded, being sick, in trouble and in other drug-using activities, etc.

None or not much better					Better				Much Better
1	2	3	4	5	6	7	8	9	10

Remarks: _____

Health: Has your health improved? In what way and how much? Think about your physical and mental health: Are you eating and sleeping properly, exercising, taking care of health problems or dental problems, feeling better about yourself, etc?

None or not much better					Better				Much Better
1	2	3	4	5	6	7	8	9	10

Remarks: _____

Lifestyle: How much better are you in taking care of personal responsibilities? Think about your living conditions, family situation, employment, relationships: Are you paying your bills? Following through with your personal or professional commitments?

None or not much better					Better				Much Better
1	2	3	4	5	6	7	8	9	10

Community: Are you a better member of the community? Think about things like obeying laws and meeting your responsibilities to society: Do your actions have positive or negative impacts on other people?

None or not much better					Better				Much Better
1	2	3	4	5	6	7	8	9	10

Name: _____ Date: _____ First TEA?: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-2+1)

Name: _____ Date: _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

2. Little Interest or pleasure in doing things.

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

3. Feeling down, depressed, or hopeless.

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

4. Thoughts that you would be better of dead, or of hurting yourself

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

CLINICAL OPIATE WITHDRAWAL SCALE (COWS)

For each item, circle the number that best describes the patient's sign or symptom. Rate on just the apparent relationship to opiate withdrawl. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Date: _____

Time: _____

Resting Pulse Rate: _____ beats/minute

Measured after the patient is sitting or lying for 1 minute.

- ☐ 0 — pulse rate 80 or below
- ☐ 1 — pulse rate 81-100
- ☐ 2 — pulse rate 101-120
- ☐ 4 — pulse rate greater than 120

Sweating:

Over past 1/2 hour not accounted for by room temperature or patient activity.

- ☐ 0 — no report of chills or flushing
- ☐ 1 — subjective report of chills or flushing
- ☐ 2 — flushed or observable moistness on face
- ☐ 4 — sweat streaming off face

Restlessness:

Observation during assessment

- ☐ 0 — able to sit still
- ☐ 1 — reports difficulty sitting still, but is able to do so
- ☐ 3 — Frequent shifting or extraneous movements of legs/arms
- ☐ 5 — Unable to sit still for more than a few seconds

Pupil Size:

- ☐ 0 — pupils pinned or normal size for room light
- ☐ 1 — pupils possibly larger than normal for room light
- ☐ 3 — pupils moderately dilated
- ☐ 5 — pupils so dilated that only the rim of the iris is visible

Bone or joing aches:

If patient was having pain previously, only the additional component atributed to opiates withdrawl is scored

- ☐ 0 — not present
- ☐ 1 — mild diffuse discomfort
- ☐ 2 — patient reports severe diffuse aching of joints/muscles
- ☐ 4 — patient is rubbing joints or muscles and is unable to sit still because of discomfort

Runny nose or tearing:

Not accounted for by cold symptoms or allergies

- ☐ 0 — not present
- ☐ 1 — nasal stuffiness or unusually moist eyes
- ☐ 2 — nose running or tearing
- ☐ 4 — nose constantly running or tears streaming down cheeks

GI Upset:

Over last 1/2 hour

- ☐ 0 — no GI symptoms
- ☐ 1 — stomach cramps
- ☐ 2 — nausea or loose stool
- ☐ 4 — vomiting or diarrhea
- ☐ 5 — multiple episodes of diarrhea or vomiting

Tremor:

Observation of outstretched hands

- ☐ 0 — no tremor
- ☐ 1 — tremor can be felt, but not observed
- ☐ 2 — slight tremor observable
- ☐ 4 — gross tremor or muscle twitching

Yawning:

Observation during assessment

- ☐ 0 — no yawning
- ☐ 1 — patient reports increasing irritability or anxiousness
- ☐ 2 — yawning three or more times during assessment
- ☐ 4 — yawning several times/minute

Anxiety or Irritability:

- ☐ 0 — none
- ☐ 1 — patient reports increasing irritability or anxiousness
- ☐ 2 — patient obviously irritable anxious
- ☐ 4 — patient so irritable or anxious that participation in the assessment is difficult

Gooseflesh skin:

- ☐ 0 — skin is smooth
- ☐ 3 — piloerrection of skin can be felt or hairs standing up on arms
- ☐ 5 — prominent piloerrection

The total score is the sum of all items: _____

Score:

- ☐ 5-12 = Mild
- ☐ 13-24 = Moderate
- ☐ 25-36 = Moderately severe
- ☐ More than 36 = Severe withdrawl

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

2. Feeling down, depressed, or hopeless

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

3. Trouble falling/staying asleep, sleeping too much

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

4. Feeling tired or having little energy

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

5. Poor appetite or overeating

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

6. Feeling bad about yourself or that you are a failure or have let yourself or your family down

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television.

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

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.

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way.

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

If you checked off any problem on this questionnaire so far, 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

PHQ-9* QUESTIONNAIRE FOR DEPRESSION SCORING AND INTERPRETATION GUIDE

For physician use only

Scoring:
Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all ..... (#) _____ x 0 = _____
Several days ..... (#) _____ x 1 = _____
More than half the days ..... (#) _____ x 2 = _____
Nearly every day ..... (#) _____ x 3 = _____

Total score: _____

Interpreting PHQ-9 Scores

Minimal depression: **0-4**
Mild depression: **5-9**
Moderate depression: **10-14**
Moderately severe depression: **15-19**
Severe depression: **20-27**

** PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website www.depression-primarycare.org/clinicians/toolkits/materials/forms/p*

Actions Based on PH9 Score

<4 The score suggests the patient may not need depression treatment.

>5-14 Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.

>15 Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

PROMIS PAIN INTERFERENCE SHORT FORM

Please respond to each item by marking one box per row.

In the past 7 days...

1. How much did pain interfere with your enjoyment of life?

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much

2. How much did pain interfere with your ability to concentrate?

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much

3. How much did pain interfere with your day to day activities?

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much

4. How much did pain interfere with your enjoyment of recreational activities?

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much

5. How much did pain interfere with doing your tasks away from home (e.g. getting groceries, running errands)?

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much

In the past 7 days...

6. How often did pain keep you from socializing with others?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Emotional Distress

Please answer the following questions.

1. In the past month, have you wished you were dead or wished you could go to sleep and not wake up?
   - ☐ No
   - ☐ Yes
2. In the past month, have you actually had any thoughts about killing yourself?
   - ☐ No
   - ☐ Yes
3. In the past month, have you thought about how you might kill yourself?
   - ☐ No
   - ☐ Yes
4. In the past month, have you had any intention of acting on these thoughts of killing yourself, as opposed to you have thoughts but you definitely would not act on them?
   - ☐ No
   - ☐ Yes
5. In the past month, have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
   - ☐ No
   - ☐ Yes
6. In the past 3 months, have you ever done anything, started to do anything, or prepared to do anything to end your life? (Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.)
   - ☐ No
   - ☐ Yes
7. In your entire lifetime, how many times have you done any of these things?

Intensity

Please answer following questions.

1. How many times have you had these thoughts?
   - ☐ Less than once a week
   - ☐ Once a week
   - ☐ 2-5 times a week
   - ☐ Daily and almost daily
   - ☐ Many times each day

2. When you have the thoughts, how long do they last?

- ☐ Fleeting- few seconds or minutes
- ☐ Less than 1 hour/some of the time
- ☐ 1-4 hours/a lot of time
- ☐ 4-8 hours/ most of day
- ☐ More than 8 hours/persistent or continuous

3. Could/can you stop thinking about killing yourself or wanting to die if you want to?

- ☐ Do not attempt to control thoughts
- ☐ Easily able to control thoughts
- ☐ Can control thoughts with little difficulty
- ☐ Can control thoughts with some difficulty
- ☐ Can control thoughts with a lot of difficulty
- ☐ Unable to control thoughts

4. Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?

- ☐ Does not apply
- ☐ Deterrents definitely stopped you from attempting suicide
- ☐ Deterrents probably stopped you
- ☐ Uncertain that deterrents stopped you
- ☐ Deterrents most likely did not stop you
- ☐ Deterrents definitely did not stop you

5. What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?

- ☐ Does not apply
- ☐ Completely to get attention, revenge, or a reaction from others
- ☐ Mostly to get attention, revenge, or a reaction from others
- ☐ Equally to get attention, revenge, or a reaction from others and to end/stop the pain
- ☐ Mostly to end or stop the pain (you couldn't get on living with the pain or how you were feeling)
- ☐ Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling)