Client Code: _____ Assessor: _____ Date: _____

MAPNET Assessment Battery
Follow-Up

Clinician Ratings:

- ☐ Brief Demographic Form
- ☐ Education & Employment
- ☐ Service Use
- ☐ Social & Role Functioning Scales
- ☐ Symptom Severity Ratings (COMPASS-10)
- ☐ Alcohol, Smoking, and Substance Involvement Form
- ☐ Family Involvement
- ☐ Questions for Prescribers

Client Self–Report:

- ☐ Colorado Symptom Index
- ☐ Autonomy Support Scale
- ☐ Medication
- ☐ Quality of Life Rating Scale
- ☐ Process of Recovery Questionnaire
- ☐ Client Satisfaction Questionnaire

Packet checked by (initial & date) _____

Data entered by (initial & date) _____

Client Code: _____ Assessor: _____ Date: _____

Demographic & Background Information

1. Age: ___ ___ (Years) ___ ___ (Months)

2. Assessment Date: ___ ___ (Month) ___ ___ (Year)

3. Primary Psychosis Diagnosis:
   - ☐ Schizophrenia - 1
   - ☐ Schizophreniform disorder - 2
   - ☐ Schizoaffective disorder - 3
   - ☐ Other non-affective psychoses - 4
   - ☐ Major depression with psychotic features - 5
   - ☐ Bipolar disorder with psychotic features - 6
   - ☐ Substance induced psychotic disorder - 7
   - ☐ Other (Specify: _____) - 8
   - ☐ None/Not applicable - 97

4. Other Current & Lifetime Diagnoses:
   - ☐ Substance use disorder - 1
   - ☐ Depressive disorder - 2
   - ☐ Bipolar disorder (I/II/Cyclothymic/NOS) - 3
   - ☐ Obsessive compulsive & related disorder - 4
   - ☐ Trauma and stressor related disorder - 5
   - ☐ Anxiety disorder (Panic/Agoraphobia, Social/Specific phobia/GAD/NOS) - 6
   - ☐ Developmental or Learning Disability - 7
   - ☐ Other (Specify: _____) - 8

5. What is your zip code? _____

6. Current housing situation
   - ☐ Alone or with roommates (unsupervised) - 0
   - ☐ Living with family in community - 1
   - ☐ Supervised apartment (some staff support) - 2
   - ☐ Group home - 3
   - ☐ Residential treatment/crisis stabilization unit - 4
   - ☐ Homeless shelter, couch surfing, or sleeping outdoors - 5
   - ☐ Other (specify: _____) - 6
   - ☐ Unsure/Don't know - 98
   - ☐ Prefer not to say - 99

7. Have you been homeless at all during the past 6 months (includes staying at a shelter, temporarily with friends/family, or sleeping outdoors)? ☐ No - 0 ☐ Yes – 1

8. In the past 6 months, have you…
   a. Been the victim of a crime? ☐ Yes - 1 ☐ No - 0 ☐ Unknown - 98
   b. Had legal issues, probation, or parole? ☐ Yes - 1 ☐ No - 0 ☐ Unknown - 98
   c. Spent any nights in jail/prison? ☐ Yes - 1 ☐ No - 0 ☐ Unknown - 98
      If yes, # of nights: _____
   d. Had court-ordered treatment? ☐ Yes - 1 ☐ No - 0 ☐ Unknown - 98

9. Insurance Status
   - ☐ No Insurance - 0
   - ☐ Commercial (private) insurance (e.g., Blue Cross Blue Shield, Harvard Pilgrim) - 1
   - ☐ MassHealth or Medicaid - 2
   - ☐ Other - 3

10. Do you receive financial support from any of the following people? (*Check all that apply*)
   - ☐ Mother - 1
   - ☐ Father - 2
   - ☐ Guardian - 3
   - ☐ Spouse - 4
   - ☐ Other (specify: _____) - 5
   - ☐ Unsure/Don't know - 98
   - ☐ I do not receive financial support from anyone - 0

11. Do you currently receive any of the following other monetary supports? *(Check all that apply)*
   - ☐ No - 0
   - ☐ SSI/SSDI - 1
   - ☐ Disability benefits other than SSI/SSDI - 2
   - ☐ TANF or other income assistance - 3
   - ☐ Unemployment - 4
   - ☐ Supplemental Nutrition Assistance Program (SNAP) / Food Stamps - 5
   - ☐ Other (specify: _____) - 6
   - ☐ Unsure/Don't know - 98

12. Have you applied for SSI/SSDI in the past six months?
   - ☐ Yes - 1
   - ☐ No – 0

Client Code: _____ Assessor: _____ Date: _____

Education & Employment Form

1. What is the highest grade you have completed? *(Select one)*
   - ☐ 8th grade or less - 0
   - ☐ Some high school - 1
   - ☐ Received GED - 2
   - ☐ High school diploma - 3
   - ☐ Some college, including AA & technical certificates or diploma - 4
   - ☐ Graduated 4-year college - 5
   - ☐ Advanced degree (e.g., MA, MD, PhD) - 6
   - ☐ Unsure/Don't know - 98

2. Current school enrollment? *(Select one)*
   - ☐ Not enrolled - 0
   - ☐ Vocational support program (e.g., BU Rehab, NITEO) - 1
   - ☐ Enrolled full-time - 2
   - ☐ Enrolled part-time - 3

3. Do you currently receive educational support and accommodation through an Individualized Education Plan (IEP), 504 plan, or from your college disability support office?
   - ☐ Yes - 1
   - ☐ No - 0
   - ☐ Not applicable - 97
   - ☐ Unsure/Don't know - 98

4. Do you have a goal related to school at this time, for example, to graduate or improve your grades?
   - ☐ Yes - 1
   - ☐ No - 0
   - ☐ Not applicable - 97
   - ☐ Unsure/Don't know - 98

5. Do you have a goal related to employment at this time, for example, to get a job or find a new job?
   - ☐ Yes - 1
   - ☐ No - 0
   - ☐ Unsure/Don't know - 98

6. Have you had an internship, apprenticeship, or done volunteer work any time in the past 6 months?
   - ☐ Yes, unpaid - 1
   - ☐ Yes, paid - 2
   - ☐ No - 0
   - ☐ Unsure/Don't know - 98

7. Have you had a paid job any time in the past 6 months?
   - ☐ Yes, part-time (<30 hr/wk) - 1
   - ☐ Yes, full-time (30+ hr/wk) - 2
   - ☐ No - 0
   - ☐ Unknown – 98

8. Do you currently receive any disability or unemployment benefits (e.g., SSI)?
   - ☐ Yes - 1
   - ☐ No, never received - 0
   - ☐ No, but used to receive – 2
   - ☐ Unsure/Don't know - 98

9. On a scale of 1-10, how important is a job to you?

1	2	3	4	5	6	7	8	9	10

Not at all Very much

10. On a scale of 1-10, how confident are you that you can be successfully employed?

1	2	3	4	5	6	7	8	9	10

Not at all Very much

Client Code: _____ Assessor: _____ Date: _____

Service Use Form

Obtain information directly from client and/or family member

1. During the past 6 months, did you spend the night in a hospital for a **mental health** reason?

   ☐ Yes - 1 → a. How many hospitalizations (past 6 months)? _____
   ☐ No - 0 b. How many total nights in the hospital (past 6 months)? _____

2. During the past 6 months, did you go to the emergency room for a **mental health or substance use** reason but did not stay overnight at the hospital?

   ☐ Yes - 1 → a. How many times did you go to the emergency room? _____
   ☐ No - 0

3. During the past six months, did you spend the night in a hospital, detox facility, or a residential treatment facility for **substance use**?

   ☐ Yes - 1 → a. How many admissions (past 6 months)? _____
   ☐ No - 0 b. How many total nights in the facility (past 6 months)? _____

4. During the past 6 months, apart from mental health or substance use treatment, did you spend the night in a hospital for a **medical condition**?

   ☐ Yes - 1 → a. How many hospitalizations (past 6 months)? _____
   ☐ No - 0 b. How many total nights in the hospital (past 6 months)? _____

5. During the past 6 months, did you go to the emergency room for a **non-psychiatric medical reason**?

   ☐ Yes - 1 → a. How many times did you go to the emergency room? _____
   ☐ No - 0

6. Are you a DMH client?

   ☐ Yes – 1 ☐ No – 0

7. Since the last assessment *(or in the past 6 months, if baseline)*, has a child protective services/DCF report been filed?

   ☐ Yes - 1 ☐ No – 0 ☐ Unknown – 98

8. Has the client received the following services through your program since the last assessment?

	Yes - 1	No - 0	Unknown - 98	Service not provided - 97
a. Psychiatric medication management	☐	☐	☐	☐
b. Psychotherapy (individual or group)	☐	☐	☐	☐
c. Supported education assistance	☐	☐	☐	☐
d. Supported employment assistance	☐	☐	☐	☐
e. Case management	☐	☐	☐	☐
f. Peer support	☐	☐	☐	☐
g. Family treatment/support	☐	☐	☐	☐
h. Visits in the community	☐	☐	☐	☐

Client Code: _____ Assessor: _____ Date: _____

Prompts for Social Functioning Scale

Specific questions to aid in rating the Social Functioning scale are provided below. Be sure to focus your assessment on the **past month**.

1) Tell me about your social life. Do you have friends?

2) Are they casual or close friends? If only casual – are they school or work friends only? If close – how long have you been close friends?

3) How often do you see friends? Do you see them outside of work/school? When was the last time you saw one of your friends outside of work/school? (Attempt to determine actual amount of social contact versus perceived amount of social contact.)

4) Do you usually initiate contact or activities with friends or do they typically call or invite you? Do you ever avoid contact with friends?

5) Do you ever have problems/falling outs with friends? Arguments or fights?

6) Are you dating or interested in dating? (Alter as needed to assess age appropriate intimate relationships)

7) Do you spend time with family members (at home)? How often do you communicate with them? Do you ever avoid contact with family members?

Client Code: _____ Assessor: _____ Date: _____

Social Functioning Scale (GF: Social)

(Global Functioning: Social Scale)

CURRENT: _____

Please rate the individual's most impaired level of functioning in the **past month**. Rate actual functioning regardless of etiology of social problems.

Note: The emphasis is on social contact/interactions with people other than family members, unless these are the only interpersonal contacts a person has (e.g., the lower end of the scale). Also note that ratings of intimate relationships are secondary to the rating of primary friendships and should take into account the age of the individual. For example, older individuals may be expected to have intimate relationships involving steady dating, cohabitation, or marriage whereas younger individuals may be expected to have only romantic interests (i.e., flirtations or crushes) or close friendships.

Superior Social/Interpersonal Functioning	
Criteria: **10**	**Superior functioning in a wide range of social and interpersonal activities.** Frequently seeks out others and has multiple satisfying interpersonal relationships, including multiple close and casual friends. Is sought out by others because of his or her many positive qualities. Age appropriate involvement in intimate relationships.
Above Average Social/Interpersonal Functioning	
Criteria: **9**	**Good functioning in all social areas, and interpersonally effective.** Interested and involved in a wide range of social and interpersonal activities, including both close and casual friends. Age appropriate involvement in intimate relationships. No more than everyday interpersonal problems or concerns (e.g., an occasional argument with spouse, girlfriend/boyfriend, friends, co-workers, or classmates). Able to resolve such conflicts appropriately.
Good Social/Interpersonal Functioning	
Criteria: **8**	**Some transient mild impairment in social functioning.** Mild social impairment is present, but transient and expectable reactions to psychosocial stressors (e.g., after minor arguments with spouse, girlfriend/boyfriend, friends, co-workers, or classmates). Has some meaningful interpersonal relationships with peers (casual and close friends), and/or age appropriate intimate relationships. Infrequent interpersonal conflict with peers.
Mild Problems In Social/Interpersonal Functioning	
Criteria: **7**	**Some persistent mild difficulty in social functioning.** Mild impairment present that is NOT just expectable reaction to psychosocial stressors (e.g., mild conflicts with peers, co-workers or classmates; difficulty resolving conflicts appropriately). Has some meaningful interpersonal relationships with peers (casual and/or close friends). Some difficulty developing or maintaining age appropriate intimate relationships (e.g., multiple short-term relationships).
Moderate Impairment In Social/Interpersonal Functioning	
Criteria: **6**	**Moderate impairment in social functioning.** Moderate impairment present (e.g., few close friends; significant but intermittent conflicts with peers, co-workers or classmates). Moderate difficulty developing age appropriate intimate relationships (e.g., infrequent dating). Occasionally seeks out others, but will respond if invited by others to participate in an activity.

Client Code: _____ Assessor: _____ Date: _____

Serious Impairment In Social/Interpersonal Functioning	
Criteria: **5**	**Serious impairment in social functioning**. No close friends or intimate partner, but has some casual social contacts (e.g., acquaintances, school/work friends only). Rarely seeks out others. Occasional combative or verbally argumentative behavior with peers. Beginning to withdraw from family members (e.g., doesn't initiate conversation with family, but will respond if addressed).
Major Impairment In Social And Interpersonal Functioning	
Criteria: **4**	**Major impairment in social functioning**. Serious impairment in relationships with friends or peers (e.g., very few or no friends, frequent conflicts with friends, or frequently avoids friends). Frequent combative or verbally argumentative behavior with peers. Infrequent contact with family members (e.g., sometimes does not respond to family or avoids family members).
Marginal Ability To Function Socially	
Criteria: **3**	**Marginal ability to function socially or maintain interpersonal relationships**. Frequently alone and socially isolated. Serious impairment in relationships with all peers, including acquaintances. Few interactions with family members (e.g., often alone in room). Serious impairment in communication with others (e.g., avoids participating in most social activities).
Inability To Function Socially	
Criteria: **2**	**Unable to function socially or to maintain any interpersonal relationships.** Typically alone and socially isolated. Rarely leaves home. Rarely answers the phone or the door. Rarely participates in interactions with others at home or in other settings (e.g., work, school).
Extreme Social Isolation	
Criteria: **1**	**Extreme social isolation.** No social or family member contact at all. Doesn't leave home. Refuses to answer the phone or door.

NOTE: This scale has been partially derived from the Social and Occupational Functioning Assessment Scale (SOFAS) from DSM-IV and the GAF as it appears in the SOPS. Item content has been changed to focus specifically on social and interpersonal functioning.

Citation: Auther, A.M., Smith, C.W. & Cornblatt, B.A. (2006). *Global Functioning: Social Scale (GF: Social).* Glen Oaks, NY: Zucker Hillside Hospital.

Client Code: _____ Assessor: _____ Date: _____

Prompts for Occupational Functioning Scale

Specific questions to aid in rating the GF: Role scale are provided below. Be sure to focus your assessment on the **past month**.

Default Roles: If under 18 years of age and the patient has not dropped out or graduated from high (secondary) school, the default role is School. If 18+ and patient is no longer attending school, default role is Work. If patient is engaged in multiple roles, consider TOTAL amount of time spent in role-related activities (i.e., part-time school plus part-time work equals full-time role status).

1. How do you spend your time during the day? Do you attend school and/or have a job? (If role is work and the person is not working, ask if he/she has worked in the recent past or is currently pursuing work.)

2. IF CURRENTLY WORKING:

   a. Where do you work? What are your job responsibilities?

   b. How many hours a week do you work?

   c. How long have you been at your current job? Have you had any recent changes in your job status (e.g., lost job, stopped working, changed position or workload)?

   d. Do you usually need assistance or regular supervision at work? How often do you need extra help? Are there any tasks you are not able to do alone?

   e. Do you ever have trouble keeping up? Are you able to catch up if you fall behind?

   f. Have you received any comments (positive or negative) or formal reviews regarding your performance? Have others pointed out things that you've done well or poorly?

3. IF CURRENTLY ATTENDING SCHOOL:

a. What type of school do you attend? (general education, non-public school, residential/hospital)

b. Have you ever been in special education classes or other non-general education classes?

c. How long have you been at this school? Have you had any recent changes in your school placement?

d. Do you receive any extra help or accommodations in your classes? Do you receive tutoring or extra help in school or after school? Do you receive extra time to take tests or are you able to leave the classroom to take tests in a quiet place?

e. Do you have trouble keeping up with your coursework? Are you able to catch up if you fall behind?

f. How are your grades (obtain highest and lowest)? Are you failing any classes?

4. IF A HOMEMAKER:

a. What are your responsibilities around the house or for the family?

b. How long have you been in charge of the home?

c. How many hours per week do you spend working on household tasks?

d. Are you able to keep up with the demands of your household? Do you ever fall behind? If so, are you able to catch up, or do you need others' help? Are you avoiding any tasks? Do you need regular assistance or supervision for any tasks within the home?

e. Have you received any comments (positive or negative) regarding your performance? Have others pointed out things that you've done well or poorly?

Client Code: _____ Assessor: _____ Date: _____

MIRECC-GAF: Occupational Scale

CURRENT: _____

Primary Role used for this rating: ☐ **Student** ☐ **Worker** ☐ **Homemaker**

For this scale, enter score based on the participant's primary role during this period – Student, Worker, or Homemaker. Assign scores based on participant's average level of functioning during the month prior to the date of administration of the scale.

Student: Occupational Scale		
Fully Functional		
90-100	*Performance in school: Consider grades; difficulty and number of classes; ability to meet class requirements in a timely manner; need for academic supports beyond norm in community.* *Participation in school-based or extracurricular activities: Consider level of involvement and difficulty. School attendance should be consistent.*	Very high level of functioning with excellent grades and challenging array of activities.
80-89		High level of functioning with good grades and average array of activities.
70-79		Satisfactory level of functioning with some minor difficulties maintaining school program.
Borderline Functional		
60-69	*Performance in school: Significantly lower than expected (e.g., lower grades, reduced class load, missed assignments and need for extensions, and/or need for extra supports).* *Participation in school-based or extra-curricular activities: Extra-curricular activities markedly reduced, performed with impairment, or eliminated. School attendance sometimes inconsistent, with some negative consequences. Score lower in the range for a greater number of problems and for greater severity.*	For 60-69, must be passing all classes with grades above D. Score within upper end of range (65-69) if moderate problems in one area.
50-59		In school with significant impairment in academic performance; or has significant problems with attendance or extra-curricular activities
Dysfunctional		
40-49	*Performance in school*: Not necessarily failing, but preponderance of very poor grades. May have limited attendance. May require extensive assistance.	
30-39	Attends school OCCASIONALLY but failing most or all classes.	
20-29	Not attending school at all or attending school and failing all classes.	
Dangerousness		
10-19	Not able to obtain 1-2 of the following: food, shelter, clothing, and basic hygiene.	
1-9	Not able to obtain 3-4 of the following: food, shelter, clothing, and basic hygiene.	
0	No information available.	

Rate lower within the decile if the individual has accommodations or a modified schedule. For students on summer vacation or enrolled for the fall, score based on most recent academic performance, and rate up or down in decile on the basis of other activities and responsibilities. This does not apply to individuals who could be in the labor force or who would be expected to be a student as their primary role; score these individuals using the Worker or Student columns, respectively.

Client Code: _____ Assessor: _____ Date: _____

Worker: Occupational Scale		
Fully Functional		
90-100	Working competitively* and excelling in the workplace (e.g., getting promotions; highly valued by supervisors, etc.).	
80-89	Working competitively* and doing well at work but not excelling.	
70-79	Working competitively* and having minor difficulties at work; occasional problems with attendance, performance, or work relations.	
Borderline Functional		
60-69	*Consider need for additional supports, such as from a vocational program.*	Working competitively* with moderate impairment in performance or work relations; or has moderate problems with attendance or working the scheduled number of hours.
50-59		Working competitively* with significant impairment in performance or work relations; or has significant problems with attendance or working the scheduled number of hours.
Dysfunctional		
40-49	*Consider other activities, or contributions to household such as housework and childcare, or managing some kind of income (e.g., allowance, SSI/SSDI checks).*	Working a considerable number of hours in a noncompetitive work setting.** Also performing at least one other activity (see sidebar to the left).
30-39		Working some hours in a noncompetitive work setting** with minimal participation in other activities.
20-29		No work activities. Score higher within range if other activities accomplished.
Dangerousness		
10-19	Not able to obtain 1-2 of the following: food, shelter, clothing, and basic hygiene.	
1-9	Not able to obtain 3-4 of the following: food, shelter, clothing, and basic hygiene.	
0	No information available.	

Competitive work (indicated in anchors with "*") *includes jobs paying at least minimum wage and for which anyone in the community can apply. Off-the-books work can also be considered competitive, as long as the worker is paid at least minimum wage. If a person works for a family member or a close friend, consider the extent to which the person's position is protected or limited by those family or friend relationships when deciding whether those jobs are competitive. Jobs set aside for people with mental illness or other disabilities are not considered competitive work.*

Noncompetitive work (indicated in anchors with "**") *includes work in sheltered workshops or jobs completed with family members or close friends only. If person is working for a family member or friends, consider the extent to which individual's position is limited or protected by these relationships.*

Client Code: _____ Assessor: _____ Date: _____

Homemaker/Not in Labor Force: Occupational Scale		
Fully Functional		
90-100	*Keeps home orderly and clean; completes household tasks; and cares for children consistently (no untreated injuries/illnesses; children properly supervised and provided appropriate meals and clothing).*	Requires no assistance and completes all tasks in an exceptional manner.
80-89		Requires little assistance and completes most tasks well.
70-79		Completes tasks at an acceptable level but has some minor difficulties.
Borderline Functional		
60-69	*Requires regular assistance with some cleaning, household or child care duties. Without such help, keeps home somewhat untidy; only partially completes household tasks; and cares for children inconsistently (no untreated injuries/illnesses but preventive medical/dental care can be improved; meals are sometimes nutritionally unbalanced or skipped; children have few clean clothes; children are bathed when dirty rather than regularly; supervision outside of home is provided, but sometimes supervision inside the home is lacking). Score lower in the range for greater number of problems and for increased assistance needed.*	Score within upper end of range (65-69) if only minor problems in one area.
50-59		Score within lower end of range (50-55) if moderate problems in all three areas, including tidiness, other household tasks, and childcare; or severe problems in one area.
Dysfunctional		
40-49	*Requires extensive help with childcare, home cleaning, and household duties. Without help, home is untidy, ranging from lots of dust, dirty dishes, and trash piled in rooms; to vermin or pest infestation, smells of mildew, and home layered with dirt, debris, or food waste. Without help, care for children is inadequate (inadequate medical attention, meals provided about once a day or less; children are lacking 1-2 basic items of clothing or some essential items are in very poor condition; inappropriate or no supervision). Score lower in the range for greater number of problems and for increased assistance needed.*	Severe difficulty and need for help in one area (score within lower end of range for inadequate performance as the severity and number of problems increase).
30-39		Makes contributions to two or three of these areas, but generally needs significant help.
20-29		Makes minor contributions to one or two of the three areas, but generally needs significant help.
Dangerousness		
10-19	Not able to obtain 1-2 of the following: food, shelter, clothing, and basic hygiene.	
1-9	Not able to obtain 3-4 of the following: food, shelter, clothing, and basic hygiene.	
0	No information available.	

Client Code: _____ Assessor: _____ Date: _____

Symptom Severity Ratings

COMPASS-10 Scale

The Compass-10 scale consists of 10 items selected from the COMPASS Clinician Rating Form developed for the RAISE-ETP study. Each item includes a description of the symptom being assessed that immediately follows the name of the symptom. Following the description are suggested probe questions (in italic type) to obtain information about the symptom. Assessors should ask additional questions if the probe questions do not provide enough information to make a rating for symptom severity.

1. Depressed Mood

Sadness, grief, or discouragement (do not rate emotional indifference or empty mood here - only mood which is associated with a painful, sorrowful feeling).

Have you been feeling depressed, sad, or down?

If yes Tell me about what you have been experiencing. How often did it happen? Does it come and go? How long does it last? How bad is the feeling? (Can you stand it?)

If no: Any problems not being interested in things you usually enjoy?

If decreased interest is present, probe further for the presence of depressed mood.

Rating	0 =	**Not present**
	1 =	**Very Mild:** occasionally feels sad or "down"; of questionable clinical significance
	2 =	**Mild:** occasionally feels moderately depressed or often feels sad or "down"
	3 =	**Moderate:** occasionally feels very depressed or often feels moderately depressed
	4 =	**Moderately Severe:** often feels very depressed
	5 =	**Severe:** feels very depressed most of the time
	6 =	**Very Severe:** constant extremely painful feelings of depression
	99	Unable to assess (e.g. subject uncooperative or incoherent)

2. Anxiety / Worry

Subjective experience of worry, apprehension; over-concern for present or future. Anxiety/fear from a psychotic symptom should be rated (e.g. the subject feels anxious because of a belief that he/she is about to be killed).

Have you been feeling anxious, worried or nervous?

If yes: Tell me about what you have been experiencing. What are some things you worry about or that make your nervous? How often did it happen? Does it come and go? How bad is the feeling?

If no: Would you say that you have usually been feeling calm and relaxed recently?

Rating	0 =	**Not present**
	1 =	**Very Mild**: occasionally feels a little anxious; of questionable clinical significance
	2 =	**Mild:** occasionally feels moderately anxious or often feels a little anxious or worried
	3 =	**Moderate:** occasionally feels very anxious or often feels moderately anxious
	4 =	**Moderately Severe:** often feels very anxious or worried
	5 =	**Severe:** feels very anxious or worried most of the time
	6 =	**Very Severe:** patient is continually preoccupied with severe anxiety
	99	Unable to assess (e.g. subject uncooperative or incoherent)

3. Suicidal Ideation / Behavior

The individual reports a passive death wish, thoughts of suicide, or engages in suicidal behavior (do not include self-injurious behavior without suicidal intent).

Have you had any thoughts recently about death or that you would be better off dead?

If yes: Tell me about what you have been thinking. How often do you think about death? Have you thought about hurting yourself?

If suicidal ideation is present, further suggested questions are:

Have you thought of any ways to hurt yourself?
Do these thoughts upset you?
Any times when you have tried to hurt yourself since our last visit?

Rating	0 =	**Not present**
	1 =	**Very Mild:** occasional thoughts of dying, "I'd be better off dead" or "I wish I were dead"
	2 =	**Mild:** frequent thoughts of dying or occasional thoughts of killing self, without a plan or method
	3 =	**Moderate:** often thinks of suicide or has thought of a specific method
	4 =	**Moderately Severe:** has mentally rehearsed a specific method of suicide or has made a suicide attempt with questionable intent to die (e.g. takes aspirins and then tells family)
	5 =	**Severe:** has made preparations for a potentially lethal suicide attempt (e.g. acquires a gun and bullets for an attempt)
	6 =	**Very Severe:** has made a suicide attempt with definite intent to die
	99	Unable to assess (e.g. subject uncooperative or incoherent)

Client Code: _____ Assessor: _____ Date: _____

4. Hostility / Anger / Irritability / Aggressiveness

Anger, verbal and non-verbal expressions of anger and resentment including a belligerent attitude, sarcasm, abusive language, and assaultive or threatening behavior.

Have you been feeling annoyed, angry or resentful?

If Yes: Tell me how you have been feeling. Have other people done things to make you mad?

If applicable, other suggested questions include:

Could other people tell that you were angry?
Have you done anything about your anger [for example, shout at people])?

If No: Have other people done things that could have make you mad?

Rating	0 =	**Not present**
	1 =	**Very Mild:** occasional irritability of doubtful clinical significance
	2 =	**Mild:** occasionally feels angry or mild or indirect expressions of anger, e.g. sarcasm, disrespect or hostile gestures
	3 =	**Moderate:** frequently feels angry, frequent irritability or occasional direct expression of anger, e.g. yelling at others
	4 =	**Moderately Severe**: often feels very angry, often yells at others or occasionally threatens to harm others
	5 =	**Severe:** has acted on his anger by becoming physically abusive on one or two occasions or makes frequent threats to harm others or is very angry most of the time
	6 =	**Very Severe**: has been physically aggressive and/or required intervention to prevent assaultiveness on several occasions; or any serious assaultive act.
	99	Unable to assess (e.g. subject uncooperative or incoherent)

In the past six months, has the client…

1. Had suicidal ideation? ☐ Yes - 1 ☐ No - 0 ☐ Unknown - 98
2. Had any suicide attempts? ☐ Yes - 1 ☐ No - 0 ☐ Unknown – 98
   If yes, how many times: _____
3. Had non-suicidal self-injurious behavior? ☐ Yes - 1 ☐ No - 0 ☐ Unknown - 98
4. Had violent or aggressive thoughts? ☐ Yes - 1 ☐ No - 0 ☐ Unknown - 98
5. Had violent or aggressive behavior? ☐ Yes - 1 ☐ No - 0 ☐ Unknown – 98

Client Code: _____ Assessor: _____ Date: _____

5. Suspiciousness

Expressed or apparent belief that other persons have acted maliciously or with discriminatory intent. Include persecution by supernatural or other nonhuman agencies (e.g., the devil). Note: Ratings of "2" (mild) or above should also be rated under Unusual Thought Content.

Do you ever feel uncomfortable in public? Does it seem as though others are watching you? Are you concerned about anyone's intentions toward you?

Is anyone going out of their way to give you a hard time, or trying to hurt you? Do you feel in any danger?

If an individual reports any persecutory ideas/delusions, ask the following:

How often have you been concerned that [use individual's description]? Have you told anyone about these experiences?

Rating	0 =	**Not present**
	1 =	**Very Mild**: Seems on guard. Reluctant to respond to some "personal" questions. Reports being overly self-conscious in public
	2 =	**Mild:** Describes incidents in which others have harmed or wanted to harm him/her that sound plausible. Patient feels as if others are watching, laughing, or criticizing him/her in public, but this occurs only occasionally or rarely. Little or no preoccupation.
	3 =	**Moderate:** Says others are talking about him/her maliciously, have negative intentions, or may harm him/her. Beyond the likelihood of plausibility, but not delusional. Incidents of suspected persecution occur occasionally (less than once per week) with some preoccupation.
	4 =	**Moderately Severe:** Same symptoms as moderate (level 3) above, but incidents occur frequently such as more than once a week. Patient is moderately preoccupied with ideas of persecution OR patient reports persecutory delusions expressed with much doubt (e.g. partial delusion).
	5 =	**Severe**: Delusional -- speaks of Mafia plots, the FBI, or others poisoning his/her food, persecution by supernatural forces.
	6 =	**Extremely Severe:** Same symptoms as severe (level 5) above, but the beliefs are bizarre or more preoccupying. Patient tends to disclose or act on persecutory delusions.
	99	Unable to assess (e.g. subject uncooperative or incoherent)

Client Code: _____ Assessor: _____ Date: _____

6. Unusual Thought Content

Unusual, odd, strange or bizarre thought content. Rate the degree of unusualness, not the degree of disorganization of speech. Delusions are patently absurd, clearly false or bizarre ideas that are expressed with full conviction. Consider the patient to have full conviction if he/she has acted as though the delusional belief were true. Ideas of reference/persecution can be differentiated from delusions in that ideas are expressed with much doubt and contain more elements of reality. Include thought insertion, withdrawal and broadcast. Include grandiose, somatic and persecutory delusions even if rated elsewhere. Note: If Suspiciousness is rated "5" (severe) or "6 " (extremely severe) due to delusions, then Unusual Thought Content must be rated a "3" (moderate) or above.

Have you been receiving any special messages from people or from the way things are arranged around you? Have you seen any references to yourself on TV or in the newspapers? Can anyone read your mind? Do you have a special relationship with God?

Is anything like electricity, X-rays, or radio waves affecting you? Are thoughts put into your head that are not your own? Have you felt that you were under the control of another person or force?

If an individual reports any odd ideas/delusions, ask the following:

How often do you think about [use individual's description]? Have you told anyone about these experiences? How do you explain the things that have been happening [specify]?

Rating	0 =	**Not present**
	1 =	**Very Mild**: Ideas of reference (people may stare or may laugh at him), ideas of persecution (people may mistreat him). Unusual beliefs in psychic powers, spirits, UFOs, or unrealistic beliefs in one's own abilities. Not strongly held. Some doubt.
	2 =	**Mild**: Same symptoms as very mild (level 1) above, but degree of reality distortion is more severe as indicated by highly unusual ideas or greater conviction. Content may be typical of delusions (even bizarre), but without full conviction. The delusion does not seem to have fully formed, but is considered as one possible explanation for an unusual experience.
	3 =	**Moderate**: Delusion present but no preoccupation or functional impairment. May be an encapsulated delusion or a firmly endorsed absurd belief about past delusional circumstances.
	4 =	**Moderately Severe**: Full delusion(s) present with some preoccupation OR some areas of functioning disrupted by delusional thinking.
	5 =	**Severe**: Full delusion(s) present with much preoccupation OR many areas of functioning are disrupted by delusional thinking.
	6 =	**Extremely Severe:** Full delusions present with almost total preoccupation OR most areas of functioning are disrupted by delusional thinking
	99	Unable to assess (e.g. subject uncooperative or incoherent)

Client Code: _____ Assessor: _____ Date: _____

7. Hallucinations

Reports of perceptual experiences in the absence of relevant external stimuli. When rating degree to which functioning is disrupted by hallucinations, include preoccupation with the content and experience of the hallucinations, as well as functioning disrupted by acting out on the hallucinatory content (e.g., engaging in deviant behavior due to command hallucinations). Include "thoughts aloud" ("gedankenlautwerden") or pseudohallucinations (e.g., hears a voice inside head) if a voice quality is present.

Do you ever seem to hear your name being called? Have you heard any sounds or people talking to you or about you when there has been nobody around?

If hears voices: What does the voice/voices say? Did it have a voice quality?

Do you ever have visions or see things that others do not see'?

What about smell — odors that others do not smell?

If the individual reports hallucinations, ask the following:

Have these experiences interfered with your ability to perform your usual activities/work? How do you explain them? How often do they occur?

Rating	0 =	**Not present**
	1 =	**Very Mild**: While resting or going to sleep, sees visions, smells odors, or hears voices, sounds or whispers in the absence of external stimulation, but no impairment in functioning
	2 =	**Mild**: While in a clear state of consciousness, hears a voice calling the subject's name, experiences non-verbal auditory hallucinations (e.g., sounds or whispers), formless visual hallucinations, or has sensory experiences in the presence of a modality-relevant stimulus (e.g., visual illusions) infrequently (e.g., 1-2 times per week) and with no functional impairment.
	3 =	**Moderate**: Occasional verbal, visual, gustatory, olfactory, or tactile hallucinations with no functional impairment OR non-verbal auditory hallucinations/visual illusions more than infrequently or with impairment.
	4 =	**Moderately Severe**: Experiences daily hallucinations OR some areas of functioning are disrupted by hallucinations.
	5 =	**Severe**: Experiences verbal or visual hallucinations several times a day OR many areas of functioning are disrupted by these hallucinations.
	6 =	**Extremely Severe:** Persistent verbal or visual hallucinations throughout the day OR most areas of functioning are disrupted by these hallucinations.
	99	Unable to assess (e.g. subject uncooperative or incoherent)

Client Code: _____ Assessor: _____ Date: _____

8. Conceptual Disorganization

Degree to which speech is confused, disconnected, vague or disorganized. Rate tangentiality, circumstantiality, sudden topic shifts, incoherence, derailment, blocking, neologisms, and other speech disorders. Do not rate content of speech.

This item does not have specific probe questions as it is based upon speech obtained in response to questions about other COMPASS-10 items.

Rating	0 =	**Not present**
	1 =	**Very Mild**: Peculiar use of words or rambling but speech is comprehensible
	2 =	**Mild**: Speech a bit hard to understand or make sense of due to tangentiality, circumstantiality, or sudden topic shifts.
	3 =	**Moderate**: Speech difficult to understand due to tangentiality, circumstantiality, idiosyncratic speech, or topic shifts on many occasions OR 1-2 instances of incoherent phrases.
	4 =	**Moderately Severe**: Speech difficult to understand due to circumstantiality, tangentiality, neologisms, blocking, or topic shifts most of the time OR 3-5 instances of incoherent phrases.
	5 =	**Severe**: Speech is incomprehensible due to severe impairments most of the time. Many symptom items cannot be rated by self-report alone.
	6 =	**Extremely Severe:** Speech is incomprehensible throughout interview.
	99	Unable to assess (e.g. subject uncooperative or incoherent)

9. Avolition /Apathy

Avolition manifests itself as a characteristic lack of energy, drive, and interest. Consider degree of passivity in pursuing goal-directed activities. Factor in the range of activities available to the subject (e.g. inpatient hospitalization often substantially limits the range of activities available to patients)

During the past week, how have you been spending your time?

Rating	0 =	**Not present**
	1 =	**Very Mild:** questionable decrease in time spent in goal-directed activities.
	2 =	**Mild:** spends less time in goal-directed activities than is appropriate for situation and age
	3 =	**Moderate:** initiates activities at times but does not follow through
	4 =	**Moderately Severe:** rarely initiates activity but will passively engage with encouragement
	5 =	**Severe:** almost never initiates activities; requires assistance to accomplish basic activities
	6 =	**Very Severe:** does not initiate or persist in any goal-directed activity even with outside assistance
	99	Unable to assess (e.g. subject uncooperative or incoherent)

Client Code: _____ Assessor: _____ Date: _____

10. Asociality / Low Social Drive

The subject pursues little or no social interaction, and tends to spend much of the time alone or non-interactively.

Some people are very outgoing and like to always be around people; they are "the life of the party". Other people are very reserved and like to have a lot of time alone. What type of person are you?

If extra prompt needed: Are you more reserved or more outgoing?

What types of things have you done with people during the past week?
Tell me about your friends?

Have you had a chance to see or speak with them lately?

If inpatient: How about people on the ward?

What types of things do you do with them?

Rating	0 =	**Not present**
	1 =	**Very Mild:** questionable
	2 =	**Mild:** slow to initiate social interactions but usually responds to overtures by others
	3 =	**Moderate:** rarely initiates social interactions; sometimes responds to overtures by others.
	4 =	**Moderately Severe:** does not initiate but sometimes responds to overtures by others; little social interaction outside close family members.
	5 =	**Severe:** never initiates and rarely encourages conversations or activities; avoids being with others unless prodded, may have contacts with family.
	6 =	**Very Severe:** avoids being with others (even family members) whenever possible, extreme social isolation.
	99	Unable to assess (e.g. subject uncooperative or incoherent)

Client Code: _____ Assessor: _____ Date: _____

Alcohol, Smoking, and Substance Involvement Form

WHO ASSIST 3.0, Abbreviated

Please read to patient: *I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months.*

1. In your life, which of the following substances have you ever used? *Do not include medications used according to a doctor's prescription*	**No**	**Yes**
1a. Tobacco products (cigarettes, vape, chewing tobacco, etc.)	0	1
1b. Alcoholic beverages (beer, wine, spirits, etc.)	0	1
1c. Cannabis (marijuana, pot, grass, hash, etc.)	0	1
1d. Cocaine (coke, crack, etc.)	0	1
1e. Amphetamine type stimulants (speed, diet pills, ecstasy/molly/MDMA, etc.)	0	1
1f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	1
1g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	1
1h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	1
1i. Opioids (heroin, morphine, fentanyl, prescription painkillers, etc.)	0	1
1j. Other - specify:	0	1

Probe if all answers are negative: ***"Not even when you were in school?"***	**If "No" to all items,** SKIP Question 2. PROCEED to Questions 3 and 4. **If "Yes" to any** of these items, ask Question 2 for each substance ever used, Question 3 and Question 4.

2. In the past 30 DAYS, how often have you used the substances you mentioned (FIRST DRUG, SECOND DRUG, ETC.)?	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**	**More than Once per Day**
2a. Tobacco products (cigarettes, tobacco, vape, etc.)	0	1	2	3	4	5
2b. Alcoholic beverages (beer, wine, spirits, etc.)	0	1	2	3	4	5
2c. Cannabis (marijuana, pot, grass, hash, etc.)	0	1	2	3	4	5
2d. Cocaine (coke, crack, etc.)	0	1	2	3	4	5
2e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	1	2	3	4	5
2f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	1	2	3	4	5
2g. Sedatives or Sleeping Pills (Valium, Rohypnol, etc.)	0	1	2	3	4	5
2h. Hallucinogens (LSD, acid, mushrooms, PCP, etc.)	0	1	2	3	4	5
2i. Opioids (heroin, morphine, fentanyl, prescription painkillers, etc.)	0	1	2	3	4	5
2j. Other - specify:	0	1	2	3	4	5

Client Code: _____ Assessor: _____ Date: _____

3. In the past 6 MONTHS, have you received emergency or detox treatment *(like Narcan, going to the emergency room, or medical detox)* for any of these substances?	**No**	**Yes**
3a. Tobacco products (cigarettes, vape, chewing tobacco, etc.)	0	1
3b. Alcoholic beverages (beer, wine, spirits, etc.)	0	1
3c. Cannabis (marijuana, pot, grass, hash, etc.)	0	1
3d. Cocaine (coke, crack, etc.)	0	1
3e. Amphetamine type stimulants (speed, diet pills, ecstasy/molly/MDMA, etc.)	0	1
3f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	1
3g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	1
3h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	1
3i. Opioids (heroin, morphine, fentanyl, prescription painkillers, etc.)	0	1
3j. Other - specify:	0	1

4. In the past 6 MONTHS, have you attempted to QUIT using any of these substances?	**No**	**Yes**
4a. Tobacco products (cigarettes, vape, chewing tobacco, etc.)	0	1
4b. Alcoholic beverages (beer, wine, spirits, etc.)	0	1
4c. Cannabis (marijuana, pot, grass, hash, etc.)	0	1
4d. Cocaine (coke, crack, etc.)	0	1
4e. Amphetamine type stimulants (speed, diet pills, ecstasy/molly/MDMA, etc.)	0	1
4f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	1
4g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	1
4h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	1
4i. Opioids (heroin, morphine, fentanyl, prescription painkillers, etc.)	0	1
4j. Other - specify:	0	1

Family Involvement

1. During the past six months, how frequently was the client in contact with family?
   Select one

   ☐ About daily - 1
   ☐ About weekly - 2
   ☐ About monthly - 3
   ☐ Less than monthly - 4
   ☐ Never - 5
   ☐ Unknown - 98

2. What is the client's preference for family involvement?
   Select one

   ☐ Prefers no involvement - 0
   ☐ Prefers family involvement with some restrictions - 1
   ☐ Prefers family involvement with no restrictions - 2
   ☐ Preferences were not assessed - 98

3. Have any family member received any treatment services provided by the clinical staff (e.g., family therapy, individual sessions with the client, etc.)?

   ☐ Yes - 1
   ☐ No - 0
   ☐ Does not apply - 97

4. Does the family refuse to participate in treatment?

   ☐ Yes - 1
   ☐ No - 0
   ☐ Does not apply - 97

Client Code: _____ Assessor: _____ Date: _____

Questions for Prescribers

1. **Client's height (inches): _____**

2. **Client's weight (pounds): _____**

3. **Does the client currently take any prescription medications?**
   - ☐ Yes - 1
   - ☐ No – 0 → ***SKIP rest of prescriber questions***
   - ☐ Unsure/Don't know – 98

4. **In the following table, find the name of the medication prescribed and check the range that indicates the total mgs prescribed per day. If the prescription includes multiple doses per day, add the different doses to obtain a daily total.**

Medication	Range 1	Range 2	Range 3	Dosage unknown
a. Aripiprazole (Abilify)	☐ <5 mg/day	☐ 5-15 mg/day	☐ >15 mg/day	☐
b. Asenapine (Saphris)	☐ <10 mg/day	☐ 10 mg/day	☐ >10 mg/day	☐
c. Brexpiprazole (Rexulti)	☐ <2 mg/day	☐ 2-4 mg/day	☐ >4 mg/day	☐
d. Chlorpromazine (Largactil, Thorazine)	☐ <400 mg/day	☐ 400-600 mg/day	☐ >600 mg/day	☐
e. Clozapine (Clozaril)	☐ <200 mg/day	☐ 200–600 mg/day	☐ >600 mg/day	☐
f. Fluphenazine (Prolixin)	☐ <2.5 mg/day	☐ 2.5-5.0 mg/day	☐ >5.0 mg/day	☐
g. Haloperidol (Haldol)	☐ <2 mg/day	☐ 2–6 mg/day	☐ >6 mg/day	☐
h. Loxapine (Loxitane)	☐ <10 mg/day	☐ 10–25 mg/day	☐ >25 mg/day	☐
i. Lurasidone (Latuda)	☐ <40 mg/day	☐ 40–80 mg/day	☐ >80 mg/day	☐
j. Olanzapine (Zyprexa, Ozace)	☐ <5 mg/day	☐ 5-15 mg/day	☐ >15 mg/day	☐
k. Paliperidone (Invega)	☐ <3 mg/day	☐ 3-6 mg/day	☐ >6 mg/day	☐
l. Perphenazine (Trilafon)	☐ <4 mg/day	☐ 4-12 mg/day	☐ >12 mg/day	☐
m. Quetiapine (Seroquel)	☐ <300 mg/day	☐ 300–600 mg/day	☐ >600 mg/day	☐
n. Risperidone (Risperdal, Zepidone)	☐ <2 mg/day	☐ 2–4 mg/day	☐ >4 mg/day	☐
o. Ziprasidone (Geodon, Zeldox)	☐ <40 mg/day	☐ 40-160 mg/day	☐ >160 mg/day	☐

4a. If the client is prescribed an oral antipsychotic not listed above, indicate the name and daily dose.

Name: _____

Dosage: _____

4b. If the client is prescribed a Long-Acting Injectable (LAI), indicate the name and dose.

Name: _____

Dosage: _____

Client Code: _____ Assessor: _____ Date: _____

5. Indicate all psychotropic medications prescribed. If none, check here: ☐ - N/A (0)

Antidepressants
- ☐ Bupropion Hcl (Wellbutrin)
- ☐ Citalopram Hydrobromide (Celexa)
- ☐ Duloxetine Hcl (Cymbalta)
- ☐ Desvenlafazine (Pristiq)
- ☐ Escitalopram Oxalate (Lexapro)
- ☐ Fluoxetine Hcl (Prozac)
- ☐ Mirtazapine (Remeron)
- ☐ Paroxetine Hcl (Paxil)
- ☐ Sertraline Hcl (Zoloft)
- ☐ Venlafaxine Hcl (Effexor XR)
- ☐ Vilazodone (Viibryd)
- ☐ Vortioxetine (Brintellix)
- ☐ Other (Specify: _____)

Benzodiazepines
- ☐ Lorazepam (Ativan)
  - ☐ Daily
  - ☐ PRN
- ☐ Clonazepam (Klonopin)
  - ☐ Daily
  - ☐ PRN

Sedative/hypnotics
- ☐ Zolpidem (Ambien)

Mood Stabilizers
- ☐ Carbamazepine (Tegretol)
- ☐ Divalproex/ Valproic acid (Depakote)
- ☐ Lamotrigine (Lamictal)
- ☐ Lithium Citrate (Lithium)
- ☐ Lithium Carbonate (Eskalith)
- ☐ Oxcarbazepine (Trileptal)
- ☐ Topiramate (Topamax)

ADHD medications
- ☐ Amphetamine (Adderall, Vyvanse)
- ☐ Methylphenidate (Ritalin, Concerta)
- ☐ Guanfacine (Intuniv)
- ☐ Atomoxetine (Strattera)

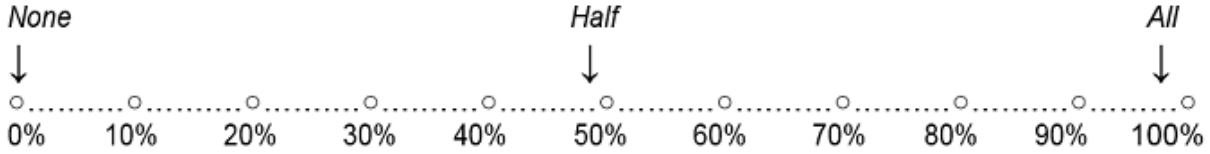
Anxiolytic
- ☐ Buspirone (Buspar)

Smoking Cessation
- ☐ Bupropion Hcl (Zyban)
- ☐ Varenacline (Chantix)

Other
- ☐ Gabapentin (Gralise)
- ☐ Trazodone Hcl (Desyrell)
- ☐ Other (Specify: _____)

6. For patients taking <u>oral antipsychotic medication</u>:

(Do not read aloud) Please place a single vertical line on the dotted line below that you believe best describes, out of the prescribed antipsychotic medication doses, the proportion of doses taken by the patient in the past month (primary antipsychotic medication only).



7. What side effects does the client currently experience from their medication?

- ☐ Daytime sedation/drowsiness/ sleeping too much - 1
- ☐ Muscles being too tense or still, or muscles trembling or shaking - 2
- ☐ Changes in appetite or weight - 3
- ☐ Changes in sexual functioning - 4
- ☐ Feeling unlike usual self - 5
- ☐ Other (specify: _____) - 10
- ☐ Blurry vision, dry mouth, constipation, or urinary retention or hesitancy - 6
- ☐ Feeling restless, jittery, or the need to move around and pace - 7
- ☐ Problems with memory or concentration - 8
- ☐ Problems with menstruation or breast problems - 9
- ☐ None - 0

CLIENT SELF REPORT BEGINS HERE

"Would you prefer to fill these out on your own, or have me read the questions out loud?"

Client Code: _____ Assessor: _____ Date: _____

Colorado Symptom Index

Below is a list of problems that people sometimes have. Please think about how often you experienced certain problems and how much they bothered or distressed you during the past month. For each problem, please pick one answer choice.

How often have you experienced these problems in the past month (30 days)?

		Not at all	Once during the month	Several times during the month	Several times a week	At least every day	Don't Know/ Skip -99
1	How often have you felt nervous, tense, worried, frustrated, or afraid?	0	1	2	3	4	
2	How often have you felt depressed?	0	1	2	3	4	
3	How often have you felt lonely?	0	1	2	3	4	
4	How often have others told you that you acted "paranoid" or "suspicious"?	0	1	2	3	4	
5	How often did you hear voices, or hear and see things that other people didn't think were there?	0	1	2	3	4	
6	How often did you have trouble making up your mind about something, like deciding where you wanted to go or what you were going to do, or how to solve a problem?	0	1	2	3	4	
7	How often did you have trouble thinking straight or concentrating on something that you needed to do (like worrying so much or thinking about problems so much that you can't remember or focus on other things)?	0	1	2	3	4	

Client Code: _____ Assessor: _____ Date: _____

		Not at all	Once during the month	Several times during the month	Several times a week	At least every day	Don't Know/ Skip -99
8	How often did you feel that your behavior or actions were strange or different from that of other people?	0	1	2	3	4	
9	How often did you feel out of place or like you did not fit in?	0	1	2	3	4	
10	How often did you forget important things?	0	1	2	3	4	
11	How often did you have problems with thinking too fast (thoughts racing)?	0	1	2	3	4	
12	How often did you feel suspicious or paranoid?	0	1	2	3	4	
13	How often did you feel like hurting yourself or killing yourself?	0	1	2	3	4	
14	How often have you felt like seriously hurting someone else?	0	1	2	3	4	

Client Code: _____ Assessor: _____ Date: _____

Autonomy Support Scale

Answer the next six statements about clinicians (doctors, nurses, case managers, therapists and others) you have seen at this center during the **past 30 days** by circling the number that represents how you feel.

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1. I feel that my clinicians have given me choices and options.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
2. My clinicians convey confidence in my ability to make changes.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
3. My clinicians encourage me to ask questions.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
4. I feel understood by my clinician.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
5. My clinician listens to how I would like to do things.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
6. My clinician tries to understand how I see things before suggesting a new way to do things.	(1)	(2)	(3)	(4)	(5)	(6)	(7)

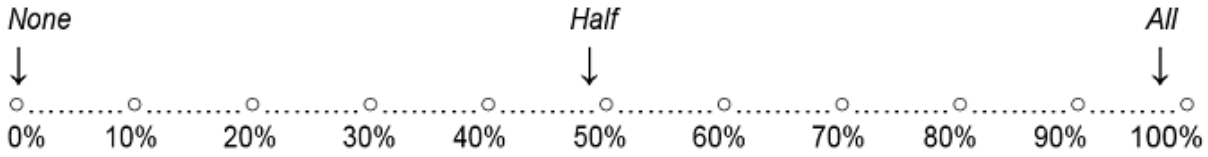
Client Code: _____ Assessor: _____ Date: _____

Medication

If you do not take any antipsychotic medication, check here and skip this question: ☐ - N/A

A. If your primary medication is a pill:

What percentage of the time (out of 100%) did you take your medication as prescribed? Please mark on the line below.



Quality of Life

Thinking about your own life and personal circumstances, how satisfied are you with your life as a whole?

- ☐ 0 - No satisfaction at all
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 - Completely satisfied

Client Code: _____ Assessor: _____ Date: _____

Process of Recovery Questionnaire

We developed this questionnaire in order to understand more about the process of recovery; what's helpful and what's not so helpful. Everyone is different and there will be differences for everyone. The items on this questionnaire were developed through a process of interviewing service users about their recovery journeys. We hope that by filing in this questionnaire you will help us find out information that is important to you and your own recovery. Not all factors will be important to you, since everyone is different. This questionnaire is not intended to be used to impose anything against your wishes.

If you would like to fill in the questionnaire, please take a moment to **consider how things stand for you at the present time, in particular over the last 7 days**, with regards to your mental health. Please respond to the following statements by circling the number which best describes your experience.

	Disagree strongly	Disagree	Neither agree nor disagree	Agree	Agree Strongly
1. I feel better about myself	0	1	2	3	4
2. I feel able to take chances in life	0	1	2	3	4
3. I am able to develop positive relationships with other people	0	1	2	3	4
4. I feel part of society rather than isolated	0	1	2	3	4
5. I am able to assert myself	0	1	2	3	4
6. I feel that my life has a purpose	0	1	2	3	4
7. My experiences have changed me for the better	0	1	2	3	4
8. I have been able to come to terms with things that have happened to me in the past and move on with my life	0	1	2	3	4
9. I am basically strongly motivated to get better	0	1	2	3	4
10. I can recognize the positive things I have done	0	1	2	3	4
11. I am able to understand myself better	0	1	2	3	4
12. I can take charge of my life	0	1	2	3	4
13. I can actively engage with life	0	1	2	3	4
14. I can take control of aspects of my life	0	1	2	3	4
15. I can find the time to do the things I enjoy	0	1	2	3	4

Client Code: _____ Assessor: _____ Date: _____

Client Satisfaction Questionnaire

Please help us improve the program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much; we really appreciate your help.

Circle your answer:

1. How would you rate the quality of service you have received?

1	2	3	4
Poor	Fair	Good	Excellent

2. Did you get the kind of service you wanted?

1	2	3	4
None of my needs have been met	Only a few of my needs have been met	Most of my needs have been met	Almost all of my needs have been met

3. To what extent has our program met your needs?

1	2	3	4
None of my needs have been met	Only a few of my needs have been met	Most of my needs have been met	Almost all of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him or her?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

7. In an overall, general sense, how satisfied are you with the service you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

8. What have you found to be most helpful in this program?

1. _____
2. _____
3. _____

9. What changes would you suggest to improve this program in the future?

1. _____
2. _____
3. _____

10. Please write any additional comments here:

_____

_____

_____

_____