Clinician ID: _________ Client ID: __________ Date: __________ Session: ______ Individual or Group Session: __________

Wildfire Mental Health Collaborative Client Follow-up Surveys

Cover Sheet

Instructions for counselors

If your client had elevated scores on PCPTSD, or ISI at intake, please administer it weekly (or at every session), before the session starts. At every session, please complete the GAD-7, PHQ-9, IPF, and the Goal Progress Questionnaire.

If your client had elevated scores on the AUDIT or CUDIT (substance use), administer once a month.

Score the surveys by summing them. For the IPF please follow the specific scoring instructions. Please note the scores on your session report/checklist for your records, and discuss them with your client.

Please be sure that the client ID and date are on the surveys and session reports. The client ID is your ID, followed by 01, 02, 03, etc. (sequential for each individual you treat as part of the collaborative. For example, if your ID is 2019-100, your first client would be 2019-100-01).

Please indicate if you are providing an individual or group session.

Please retain a copy for your records and transmit the surveys securely along with the session checklist at: http://med.stanford.edu/fastlab/sonoma.html or fax to: 650-725-6575, Attn: Wildfire MH Collaborative.

Clinician ID: _________ Client ID: __________ Date: __________ Session: ______ Individual or Group Session: __________

Wildfire Mental Health Collaborative Follow-up Surveys

The following questions will you and your counselor understand the impact the fires had on you, and your recent mood, goals, and behavior. Your counselor will ask you to complete some or all of the surveys in this packet so that you can understand whether and how you are making progress on your goals. All of your responses will be kept confidential.

Clinician ID: _________ Client ID: __________ Date: __________ Session: ______ Individual or Group Session: __________

Insomnia Severity Index

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. Past WEEK) SEVERITY of your insomnia problem(s).

Insomnia Problem	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

1. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

2. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

3. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

4. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Clinician ID: _________ Client ID: __________ Date: __________ Session: ______ Individual or Group Session: __________

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident
- a physical or sexual assault or abuse
- a fire, earthquake, or flood
- war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

At your first session you indicated that you had an experience of this kind.

In the past week, have you…

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

   ☐ Yes ☐No

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? ☐ Yes ☐No

3. been constantly on guard, watchful, or easily startled? ☐ Yes ☐No

4. felt numb or detached from people, activities, or your surroundings? ☐ Yes ☐No

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the

   event(s) may have caused? ☐ Yes ☐No

Clinician ID: _________ Client ID: __________ Date: __________ Session: ______ Individual or Group Session: __________

Patient Health Questionnaire-9

Over the past week, how often have you been bothered by the following problems?

(Circle 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 TV	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

10. If you checked off any problems above, 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 at all difficult	Somewhat difficult	Very difficult	Extremely difficult

Clinician ID: _________ Client ID: __________ Date: __________ Session: ______ Individual or Group Session: __________

GAD-7

Over the <u>past week</u>, how often have you been bothered by any of the following problems?	Not at all	Several days	More than 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 is 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

8. If you checked off any problems above, 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 at all difficult	Somewhat difficult	Very difficult	Extremely difficult

Clinician ID: _________ Client ID: __________ Date: __________ Session: ______ Individual or Group Session: __________

Goals

Please write the 3 goals that you listed at your first session. Next, please rate to what extent you feel like you made progress on these goals since your last visit.

Goals:

1. ____

No Progress	A Little Progress	Moderate Progress	A Good Deal of Progress	A Great Deal of Progress
1	2	3	4	5

2. ____

No Progress	A Little Progress	Moderate Progress	A Good Deal of Progress	A Great Deal of Progress
1	2	3	4	5

3. ____

No Progress	A Little Progress	Moderate Progress	A Good Deal of Progress	A Great Deal of Progress
1	2	3	4	5

Clinician ID: _________ Client ID: __________ Date: __________ Session: ______ Individual or Group Session: __________

Brief Inventory of Psychosocial Functioning

Overall, in the past week:	**Not at all**		**Somewhat**				**Very Much**	**Not applicable**
1. I had trouble in my romantic relationship with my spouse or partner.	0	1	2	3	4	5	6	7
2. I had trouble in my relationship with my children.	0	1	2	3	4	5	6	7
3. I had trouble with my family relationships.	0	1	2	3	4	5	6	7
4. I had trouble with my friendships and socializing.	0	1	2	3	4	5	6	7
5. I had trouble at work.	0	1	2	3	4	5	6	7
6. I had trouble with my training and education.	0	1	2	3	4	5	6	7
7. I had trouble with day to day activities, such as doing household chores, running errands and managing my medical care.	0	1	2	3	4	5	6	7

Clinician ID: _________ Client ID: __________ Date: __________ Session: ______ Individual or Group Session: __________

AUDIT-C (to be completed once a month)

Do you currently use alcohol? ☐ Yes ☐ No

IF YES:

1. How often did you have a drink containing alcohol in the past month?

☐ Never
☐ Monthly or less
☐ Two to four times a month
☐ Two to three times a week
☐ Four or more times a week

2. How many drinks did you have on a typical day when you were drinking in the past month?

☐ None, I do not drink alcohol
☐ 1 or 2
☐ 3 or 4
☐ 5 or 6
☐ 7 to 9
☐ 10 or more

3. How often did you have six or more drinks on one occasion in the past month?

☐ Never
☐ Less than monthly
☐ Monthly
☐ Weekly
☐ Daily or almost daily

4. Are you recovering from an alcohol use disorder? ☐ Yes ☐ No

CUDIT-Short Form

Do you currently use cannabis? ☐ Yes ☐ No

IF YES: How often in the past MONTH…

	Never	Less Than Monthly	Monthly	Weekly	Daily/Almost Daily
6. did you find that you were not able to stop using cannabis once you had started?					
7. have you devoted a great deal of your time to getting, using, or recovering from cannabis?					
8. have you had a problem with your memory or concentration after using cannabis?					