Wildfire Mental Health Collaborative-Intake Surveys

Brief Project Description: Thank you for taking the time to complete these measures. The following questions will help your therapist to understand your background, the impact the fires had on you, and your recent mood, goals, and behavior. In future meetings with your counselor, you may be asked to fill out brief surveys again so that you and your counselor can understand whether you are making progress on your goals, but there will be fewer questions. All of your responses will be kept confidential.

Demographic Questionnaire

1. Age: ________________________

2. Race (please circle all that apply)

☐ White/Caucasian
☐ Black or African American
☐ Middle Eastern or North African
☐ Asian
☐ American Indian or Native American
☐ Native Hawaiian or Other Pacific Islander
☐ Mixed/Multiple Races
☐ A racial, ethnic, or origin category not specified here: Please Specify: _______

3. Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino

4. Gender

☐ 1 - Male
☐ 2 - Female
☐ 3 - Transmale or trans man
☐ 4 - Transfemale or trans woman
☐ 5 - Genderqueer or gender non-conforming
☐ 6 - A gender identity not listed here: _________________________

5. Sexual Orientation (please circle)

Heterosexual/Straight Homosexual/Gay Bisexual Other

6. Marital Status (please circle)

Married Widowed Separated Divorced Never married/Single Partnered

7. Highest Education Level (please circle)

☐ Grade 6 or less
☐ Grade 7-12 (without graduating)
☐ High School Graduate or Equivalent
☐ Some College
☐ 2 year college/Associates Degree
☐ 4-year college/Bachelor's Degree
☐ Some Graduate/Professional School
☐ Completed Graduate/Professional School

8. Education in years (GED=12): ____

9. What is your current living situation?

☐ 1 - House
☐ 2 - Apartment, condominium, mobile home
☐ 3 - A camper or RV
☐ 4 - School dormitory
☐ 5 - Halfway house, group home, shelter
☐ 6 - Rooming house, SRO, motel, hotel
☐ 7 - Homeless (no regular place)
☐ 8 - Homeless and living with family or friends “couch surfing”
☐ 9 - Other Please Specify: ____

10. With whom do you currently live (circle all that apply):

☐ No one, I live alone
☐ Spouse or significant other
☐ Parent(s)
☐ Child(ren) (13-18 years old)
☐ Child(ren) under 13 years old
☐ Other family
☐ Friend(s) or acquaintances
☐ None of the above (please describe): __________

11. Are you considered disabled from work (receiving a disability pension)?

Yes No

12. Are you receiving any Social Security (SSI or SSDI)?

Yes No

13. Are you currently active in the military or a veteran?

Yes No

14. How would you describe your employment status?

☐ 1 - Full-time (35 hours/week or more)
☐ 2 - Part-time (less than 35 hours/week)
☐ 3 - Student
☐ 4 - Stay-at-home parent
☐ 5 - Active military service
☐ 6 - Disabled
☐ 7 - Unemployed
☐ 8 - Retired
☐ 9 - Other

15. What was your household income this past year before taxes? __________

Fire Proximity and Impact

1. **What was your city or town of residence when the fires began on October 8, 2017?**

   ____

2. **How long had you lived in your home prior to the fires?**
   ☐ Less than 1 month
   ☐ 1 month to less than 1 year
   ☐ 1 to 2 years
   ☐ 3 to 5 years
   ☐ 6 to 12 years
   ☐ More than 12 years

3. **Did you own the home you lived in when the fires began?**
   ☐ Yes
   ☐ No

4. **Who were you living with at the time of the fires?**
   ☐ No one, I lived alone
   ☐ Spouse or significant other
   ☐ Parent(s)
   ☐ Child(ren) (13-18 years old)
   ☐ Child(ren) under 13 years old
   ☐ Other family
   ☐ Friend(s) or acquaintances
   ☐ None of the above (please describe): ____________________________________

5. **How close did the wildfires get to the place where you were living when the fires began**
   ☐ Fire impacted my property
   ☐ One block or less but my property was not impacted
   ☐ More than 1 block to 1/2 mile away
   ☐ More than 1/2 mile to 1 mile away
   ☐ More than 1 mile to 5 miles away
   ☐ More than 5 miles away
   ☐ Don't know

6. **What is the condition of the home you were living in when the fires began?**
   ☐ Home is completely destroyed
   ☐ Home is still standing but significantly damaged from fire and/or smoke
   ☐ Home had minor damage
   ☐ Home was not damaged
   ☐ Don't know the extent of damage

7. If your house was damaged or destroyed, for which of the following did you have insurance coverage?

Type	Partial (did not cover all damage)	Full (all damage covered; total replacement/rebuild)	None	Not sure	N/A
Home (building/structure)					
Personal property (clothing, electronics, valuables)					
Cleanup (debris removal, etc.)					

8. How did you first learn about the wildfires? (Check all that apply)

☐ Smelled smoke
☐ Saw flames
☐ From a household member
☐ From a neighbor
☐ From friend of family member not in the home
☐ From law enforcement
☐ From fire department
☐ The news
☐ other

9. Were you evacuated from your home?

☐ Yes
☐ No
☐ N/a

10. If yes, were you evacuated more than once?

☐ Yes
☐ No
☐ N/a

11. If yes, did all household members remain together throughout the following 6 weeks?

☐ Yes, household members remained together, including our pets
☐ Household members remained together, but pets had to be boarded elsewhere
☐ Household members remained together, but pets were lost or missing
☐ No, household members were separated
☐ N/a

12. If yes, how long were you displaced from your home?

☐ 1-2 weeks
☐ 2 weeks-4 weeks
☐ More than a month
☐ More than two months

13. If displaced, which best describes your current housing status (check all that apply):

☐ Still displaced, home destroyed or uninhabitable but hope to rebuild
☐ Still displaced, home destroyed but we have started rebuilding
☐ Still displaced, home destroyed but have bought or rented a new home and will move into permanent housing in the next one month
☐ Still displaced and have not clarified a plan for permanent housing
☐ Still displaced and cannot locate housing
☐ Permanent displacement – my home was destroyed or is now uninhabitable
☐ Not applicable
☐ Other ____

14. Was your employment affected by the fires? (Check all that apply)

☐ No
☐ Yes, I lost work hours
☐ Yes, my job/business was relocated nearby
☐ Yes, my job/business was relocated at a distance
☐ Yes, I became unemployed
☐ Other____________________________________
☐ N/A – I was not employed

15. Please indicate your own experiences of the fires (check all that apply):

☐ Sustained an injury
☐ Knew someone who died
☐ Witnessed injuries
Witnessed survivors' emotional distress
(or Housed fire survivors)
Worked or volunteered with evacuees during the fires
☐ Minor loss of or damage to property (not your home)
☐ Major loss of or damage to property (not your home)
☐ Lost one or more pets
☐ Lost childcare due to the fires
☐ Missed school due to the fires
☐ I did not experience any of these things
☐ Other____

Individual Goals

What goals do you have for counseling?

a.

b.

c.

Individual Strengths

What do you view as your personal strengths, or things about your life that help you cope or be successful?

a.

b.

c.

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

AUDIT-C

Do you currently use alcohol? ☐ Yes ☐ No

IF YES:

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

☐ 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 year?

☐ 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 year?

☐ 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 <u>in the past 6 months</u>…

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

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. LAST 2 WEEKS) 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

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

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

5. 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

6. 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

7. 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.

Have you ever experienced this kind of event? ☐ Yes ☐ No

Please list event that was the worst or most traumatic (in brief terms, you do not need to provide details): ____

IF YES: In the past month, 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
6. How many different traumatic events have you experienced in your life? ______________
7. Were any of these events recurring or ongoing (such as ongoing abuse?) _____________

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

Patient Health Questionnaire-9

Over the last 2 weeks, 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>last 2 weeks</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: __________

Brief Inventory of Psychosocial Functioning

Overall, in the past 30 days:	**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