Perceived Stress Scale

INSTRUCTIONS:

The questions in this scale ask you about your feelings and thoughts during THE LAST MONTH. In each case, you will be asked to indicate your response by placing an “X” over the circle representing HOW OFTEN you felt or thought a certain way.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never | Almost Never | Sometimes | Fairly Often | Very Often |
| 0 | 1 | 2 | 3 | 4 |
| 1. In the last month, how often have you been upset because of something that had happened unexpectedly?
 | о | о | о | о | о |
| 1. In the last month, how often have you felt that you were unable to control the important things in your life?
 | о | о | о | о | о |
| 1. In the last month, how often have you felt nervous and “stressed”?
 | о | о | о | о | о |
| 1. In the last month, how often have you dealt successfully with day to day problems and annoyances?
 | о | о | о | о | о |
| 1. In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?
 | о | о | о | о | о |
| 1. In the last month, how often have you felt confident about your ability to handle your personal problems?
 | о | о | о | о | о |
| 1. In the last month, how often have you felt that things were going your way?
 | о | о | о | о | о |
| 1. In the last month, how often have you found that you could NOT cope with all the things that you had to do?
 | о | о | о | о | о |
| 1. In the last month, how often have you been able to control irritation in your life?
 | о | о | о | о | о |
| 1. In the last month, how often have you felt that you were on top of things?
 | о | о | о | о | о |

GAD-7

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the last 2 weeks, how often have you been bothered by 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 |
| 1. Not being able to stop or control worrying
 | 0 | 1 | 2 | 3 |
| 1. Worrying too much about different things
 | 0 | 1 | 2 | 3 |
| 1. Trouble relaxing
 | 0 | 1 | 2 | 3 |
| 1. Being so restless that it is hard to sit still
 | 0 | 1 | 2 | 3 |
| 1. Becoming easily annoyed or irritable
 | 0 | 1 | 2 | 3 |
| 1. Feeling afraid as if something awful might happen
 | 0 | 1 | 2 | 3 |
| (For office coding: Total Score T\_\_\_\_\_ = \_\_\_\_\_\_ + \_\_\_\_\_\_+ \_\_\_\_\_\_) |

**Center for Epidemiologic Studies Short Depression Scale (CES-D-R 10)**

Below is a list of some of the ways you may have felt or behaved.

Please indicate how often you have felt this way during the past week by checking the appropriate box for each question.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Rarely or none of the time(less than 1 day) | Some or a little of the time(1-2 days) | Occasionally or a moderate amount of time(3-4 days) | All of the time(5-7 days) |
| 1. I was bothered by things that usually don’t bother me.
 | ▫ | ▫ | ▫ | ▫ |
| 1. I had trouble keeping my mind on what I was doing.
 | ▫ | ▫ | ▫ | ▫ |
| 1. I felt depressed.
 | ▫ | ▫ | ▫ | ▫ |
| 1. I felt that everything I did was an effort.
 | ▫ | ▫ | ▫ | ▫ |
| 1. I felt hopeful about the future.
 | ▫ | ▫ | ▫ | ▫ |
| 1. I felt fearful.
 | ▫ | ▫ | ▫ | ▫ |
| 1. My sleep was restless.
 | ▫ | ▫ | ▫ | ▫ |
| 1. I was happy.
 | ▫ | ▫ | ▫ | ▫ |
| 1. I felt lonely.
 | ▫ | ▫ | ▫ | ▫ |
| 1. I could not “get going”.
 | ▫ | ▫ | ▫ | ▫ |

**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 |
| 1. Difficulty staying asleep
 | 0 | 1 | 2 | 3 | 4 |
| 1. 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 |

1. 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 |

1. 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 |

1. 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 |