First Name: _____

Initials: _____ _____ Date_____ Therapist:_____ **DEPRESSION SCALE**

INSTRUCTIONS

This questionnaire includes questions about symptoms of depression. For each item please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

RATING GUIDELINES

0= not at all true
1= a little bit
2= a moderate amount
3= quite a bit
4= extremely

During the PAST WEEK, INCLUDING TODAY….

1. I felt sad or depressed	0	1	2	3	4
2. I was not as interested in my usual activities	0	1	2	3	4
3. My appetite was poor and I didn't feel like eating	0	1	2	3	4
4. My appetite was much greater than usual	0	1	2	3	4
5. I had difficulty sleeping	0	1	2	3	4
6. I was sleeping too much	0	1	2	3	4
7. I felt very fidgety, making it difficult to sit still	0	1	2	3	4
8. I felt physically slowed down, like my body was stuck in mud	0	1	2	3	4
9. My energy level was low	0	1	2	3	4
10. I felt guilty	0	1	2	3	4
11. I thought I was a failure	0	1	2	3	4
12. I had problems concentrating	0	1	2	3	4
13. I had more difficulties making decisions than usual	0	1	2	3	4
14. I wished I was dead	0	1	2	3	4
15. I thought about killing myself	0	1	2	3	4
16. I thought that the future looked hopeless	0	1	2	3	4

17. Overall, how much have symptoms of depression interfered with or caused difficulties in your life during the past day?
    0) not at all
    1) a little bit
    2) a moderate amount
    3) quite a bit
    4) extremely

18. How would you rate your overall quality of life during the past day?
    0) very good, my life could hardly be better
    1) pretty good, most things are going well
    2) the good and bad parts are about equal
    3) pretty bad, most things are going poorly
    4) very bad, my life could hardly be worse

Last initial: _____ Date: _____ Therapist: _____ **ACT SCALE**

INSTRUCTIONS
For each item please indicate how well it describes you during the PAST WEEK INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

RATING GUIDELINES
0= not at all true
1= a little bit
2= a moderate amount
3= quite a bit
4= extremely

During the PAST WEEK INCLUDING TODAY….

1.	Overall, I felt very distressed (for example, anxious, depressed, and/or angry)	0	1	2	3	4
2.	I tried really hard not to feel distressed (for example, by pushing thoughts away, distracting myself, and/or reassuring myself	0	1	2	3	4
3.	I struggled with difficult thoughts	0	1	2	3	4
4.	I was aware of what is most important to me no matter what I was thinking or feeling	0	1	2	3	4
5.	I took actions in line with my values	0	1	2	3	4
6.	I watched my feelings without getting carried away by them	0	1	2	3	4
7.	I remained committed to my goals even if I faced challenges	0	1	2	3	4
8.	It seemed I was "running on automatic" without much awareness of what I was doing	0	1	2	3	4
9.	I needed to control the thoughts that came into my head	0	1	2	3	4
10.	I tried to be understanding and patient towards those aspects of myself I don't like	0	1	2	3	4
11.	I made progress in the areas of my life I care most about	0	1	2	3	4
12.	I got upset with myself for having certain thoughts	0	1	2	3	4
13.	I noticed that I was the same person even when my thoughts and feelings changed	0	1	2	3	4
14.	I was proud about how I lived my life in the past week	0	1	2	3	4
15.	I tried to see my failings as part of the human condition	0	1	2	3	4
16.	My behavior was a good example of what I stand for in life	0	1	2	3	4
17.	I told myself that I shouldn't be thinking the way I was thinking	0	1	2	3	4
18.	I chose to change how I approached a goal rather than quit	0	1	2	3	4
19.	I was defined by more than just my thoughts and feelings	0	1	2	3	4

Name:_____ Date:_____

ANXIETY SCALE

INSTRUCTIONS: This scale includes questions about the symptoms of anxiety. For each item please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

0= not at all true 1= rarely true 2= sometimes true 3= often true 4= almost always true

During the PAST WEEK, INCLUDING TODAY….

1. I felt nervous or anxious 0 1 2 3 4
2. I worried a lot that something bad might happen 0 1 2 3 4
3. I worried too much about things 0 1 2 3 4
4. I was jumpy and easily startled by noises 0 1 2 3 4
5. I felt "keyed up" or "on edge" because I was worried about things 0 1 2 3 4
6. I felt scared 0 1 2 3 4
7. I had muscle tension or muscle aches 0 1 2 3 4
8. I felt jittery 0 1 2 3 4
9. I was short of breath 0 1 2 3 4
10. My heart was pounding or racing 0 1 2 3 4
11. I had cold, clammy hands 0 1 2 3 4
12. I had a dry mouth 0 1 2 3 4
13. I was dizzy or lightheaded 0 1 2 3 4
14. I felt sick to my stomach (nauseated) 0 1 2 3 4
15. I had diarrhea 0 1 2 3 4
16. I had hot flashes or chills 0 1 2 3 4
17. I urinated frequently 0 1 2 3 4
18. I felt a lump in my throat 0 1 2 3 4
19. I was sweating 0 1 2 3 4
20. I had tingling feelings in my fingers or feet 0 1 2 3 4
21. I felt very fidgety, making it difficult to sit still 0 1 2 3 4
22. I had difficulty concentrating because my mind was on my worries 0 1 2 3 4
23. I worried a lot that something bad might happen 0 1 2 3 4
24. When I was extremely anxious, I was afraid I would lose control 0 1 2 3 4
25. Overall, how much have symptoms of anxiety interfered with or caused difficulties in your life during the past week?
    0) not at all
    1) a little bit
    2) a moderate amount
    3) quite a bit
    4) extremely

Initials: _____ _____ Date_____ Therapist:_____ **ANGER SCALE**

INSTRUCTIONS

This questionnaire includes questions about symptoms of anger. For each item please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

RATING GUIDELINES
0= not at all true
1= a little bit
2= a moderate amount
3= quite a bit
4= extremely

During the PAST WEEK, INCLUDING TODAY….

248. I felt very angry or irritable	0	1	2	3	4
249. I was grouchy	0	1	2	3	4
250. I yelled or argued	0	1	2	3	4
251. I let little things irritate me	0	1	2	3	4
252. I felt ready to explode	0	1	2	3	4
253. I lost my temper	0	1	2	3	4
254. I was rude to people	0	1	2	3	4
255. I had the urge to break or destroy things	0	1	2	3	4
256. I felt so angry I wanted to throw things	0	1	2	3	4
257. I broke or destroyed things	0	1	2	3	4
258. I had the urge to hit or hurt someone	0	1	2	3	4
259. I hit or hurt someone	0	1	2	3	4
260. I had the urge to physically hurt myself	0	1	2	3	4
261. I physically hurt myself	0	1	2	3	4

Initials: _____ _____ Date_____ Therapist:_____

Instructions. The purpose of this questionnaire is to determine how well individuals respond to treatment. The items on the scale ask about different aspects of psychological well-being such as symptoms, coping with stress, ability to function, sense of well-being, and enjoyment in life. Use the following scale to indicate how well each item describes you **for the past week**.

0= not at all or rarely true 1= sometimes true 2= often or almost always true

Symptoms

1. I felt sad or depressed…….. 0 1 2
2. I was not interested in the things I usually enjoy… 0 1 2
3. My motivation to do things was low……. 0 1 2
4. My appetite was poor. ……. 0 1 2
5. My appetite was much greater than usual …… 0 1 2
6. I had difficulty sleeping. . ……0 1 2
7. I was sleeping too much . …… 0 1 2
8. My energy level was low. ……..…… 0 1 2
9. I felt guilty. . ……..…… 0 1 2
10. I thought I was a failure.. ….……0 1 2
11. I had problems concentrating. . ……..…… 0 1 2
12. I had difficulty making decisions. . ……..…… 0 1 2
13. I wished I was dead. . ……..…… 0 1 2
14. I had thoughts about killing myself…… 0 1 2
15. I felt anxious. . ……..……..……0 1 2
16. I worried excessively. . ……..…… 0 1 2
17. I had a sense of dread or impending doom…… 0 1 2
18. I felt "on edge". . ……..…….. 0 1 2
19. I dwelled on things. . ……..…… 0 1 2
20. I got irritated easily. . ……..…… 0 1 2
21. I felt very angry or grouchy……..…… 0 1 2
22. I had arguments …… 0 1 2
23. I had headaches……..…… 0 1 2
24 I had back pain……..……. 0 1 2
25. I was bothered by aches and pains…..…… 0 1 2

Coping Ability

26. I coped well with the normal stresses and hassles of life.……0 1 2
27. I am able to bounce back from stressful situations.0 1 2
28. I could keep myself from feeling depressed…… 0 1 2
29. I easily got overwhelmed by stress.…… 0 1 2
30. I had trouble handling pressure.…… 0 1 2

Positive Mental Health

31. I felt at ease. . ……..…….0 1 2
32. I cared about things in my life. ……..…….. 0 1 2
33. I was able to have fun. . ……..……. 0 1 2
34. I saw myself as a person of value. ……. 0 1 2
35. I had a positive outlook on life. ……..…… 0 1 2
36. I feel energetic and vigorous……. ……. 0 1 2
37. When I woke up I looked forward to the day..…… 0 1 2
38. I could focus and concentrate well. ……. 0 1 2
39. I could make decisions without a lot of self-doubt… 0 1 2
40. I felt confident. ……..…… 0 1 2
41. I woke up feeling fresh and rested…….. 0 1 2
42. I had the desire to do things. ……..……. 0 1 2

Functioning

43. I was functioning well in my work (at a paid job, at home, or at school). . . ……..…… 0 1 2
44. I was participating in social activities. . . …… 0 1 2
45. I was able to fulfill my usual responsibilities. ……. 0 1 2
46. I got things accomplished and did what I wanted to do.0 1 2
47. My relationships were generally going well…… 0 1 2
48. Emotional problems caused difficulties in my work… 0 1 2
49. I did not do my work (at a paid job, at home, or at school) as well as usual. ……..…… 0 1 2
50. Emotional problems caused difficulties in my relationships with friends or family ….…… 0 1 2
51. I had trouble getting along with friends and family… 0 1 2
52. I was socially withdrawn……..…… 0 1 2

Well Being and Life Satisfaction

53. I was satisfied with life. . ……..…… 0 1 2
54. I was engaging in life rather than hiding from it…. 0 1 2
55. I was satisfied in my relationships……..…… 0 1 2
56. My life was fulfilling……..……. 0 1 2
57. My work (at a paid job, at home, or at school) was satisfying. ……..……. 0 1 2
58. I felt mentally healthy. . ……..…….. 0 1 2
59. I felt in control of my emotions. …… 0 1 2
60. I had a general sense of well-being..…… 0 1 2

First Name_____ Last Initial_____ Date_____ Therapist_____

VALUING QUESTIONNAIRE

Please read each statement carefully and then circle the number which best describes how much the statement was true for you **DURING THE PAST WEEK, INCLUDING TODAY**.

0 Not at all True	**1**	**2**	**3**	**4**	**5**	**6** Completely true		
1.	It seemed like I was just 'going through the motions,' rather than focusing on what was important to me	0	1	2	3	4	5	6
2.	I continued to get better at being the kind of person I want to be	0	1	2	3	4	5	6
3.	I made progress in areas of my life I care most about	0	1	2	3	4	5	6
4.	I tried to work towards important goals, but something always got in the way	0	1	2	3	4	5	6
5.	Difficult thoughts, feelings or memories got in the way of what I really wanted to do	0	1	2	3	4	5	6
6.	I was proud about how I lived my life	0	1	2	3	4	5	6
7.	I was basically on "auto-pilot" most of the time	0	1	2	3	4	5	6
8.	My behavior was a good example of what I stand for in life	0	1	2	3	4	5	6

First Name_____ Last Initial_____ Date_____ Therapist_____

FFMQ

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you **during the past week**.

1	2	3	4	5
never or very rarely true	rarely true	sometimes true	often true	very often or always true

1.	I'm good at finding words to describe my feelings.	1	2	3	4	5
2.	I can easily put my beliefs, opinions, and expectations into words.	1	2	3	4	5
3.	I watch my feelings without getting carried away by them.	1	2	3	4	5
4.	I tell myself I shouldn't be feeling the way I'm feeling.	1	2	3	4	5
5.	It's hard for me to find the words to describe what I'm thinking.	1	2	3	4	5
6.	I pay attention to physical experiences, such as the wind in my hair or sun on my face.	1	2	3	4	5
7.	I make judgments about whether my thoughts are good or bad.	1	2	3	4	5
8.	I find it difficult to stay focused on what's happening in the present moment.	1	2	3	4	5
9.	When I have distressing thoughts or images, I don't let myself be carried away by them.	1	2	3	4	5
10.	Generally, I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.	1	2	3	4	5
11.	When I feel something in my body, it's hard for me to find the right words to describe it.	1	2	3	4	5
12.	It seems I am "running on automatic" without much awareness of what I'm doing.	1	2	3	4	5
13.	When I have distressing thoughts or images, I feel calm soon after.	1	2	3	4	5
14.	I tell myself that I shouldn't be thinking the way I'm thinking.	1	2	3	4	5
15.	I notice the smells and aromas of things.	1	2	3	4	5
16.	Even when I'm feeling terribly upset, I can find a way to put it into words.	1	2	3	4	5
17.	I rush through activities without being really attentive to them.	1	2	3	4	5
18.	Usually when I have distressing thoughts or images I can just notice them without reacting.	1	2	3	4	5
19.	I think some of my emotions are bad or inappropriate and I shouldn't feel them.	1	2	3	4	5
20.	I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.	1	2	3	4	5
21.	When I have distressing thoughts or images, I just notice them and let them go.	1	2	3	4	5
22.	I do jobs or tasks automatically without being aware of what I'm doing.	1	2	3	4	5
23.	I find myself doing things without paying attention.	1	2	3	4	5
24.	I disapprove of myself when I have illogical ideas.	1	2	3	4	5

First Name_____ Last Initial_____ Date_____ Therapist_____

Initials: _____ _____

AAQ-II

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to indicate how well each item describes you **for the past week.**

1	2	3	4	5	6	7
never true	**very seldom true**	**seldom true**	**sometimes true**	**frequently true**	**almost always true**	**always true**

1.	My painful experiences and memories make it difficult for me to live a life that I would value.	1	2	3	4	5	6	7
2.	I'm afraid of my feelings.	1	2	3	4	5	6	7
3.	I worry about not being able to control my worries and feelings.	1	2	3	4	5	6	7
4.	My painful memories prevent me from having a fulfilling life.	1	2	3	4	5	6	7
5.	Emotions cause problems in my life.	1	2	3	4	5	6	7
6.	It seems like most people are handling their lives better than I am.	1	2	3	4	5	6	7
7.	Worries get in the way of my success.	1	2	3	4	5	6	7

First Name_____ Last Initial_____ Date_____ Therapist_____

The Personality Inventory for DSM-5 – Brief For (PID-5-BF)-Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

INSTRUCTIONS: T**his is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no right or wrong answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We'd like you to take your time and read each statement carefully, selecting the response that best describes you.**

The Personality Inventory for DSM-V—Brief Form (PID-5-BF)—Adult

Initials: _____ Date: _____

Instructions: **This is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no right or wrong answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We'd like you to take your time and read each statement carefully, selecting the response that best describes you.**

		Very False or Often False	Sometimes or Somewhat False	Sometimes or Somewhat True	Very True or Often True
1	People would describe me as reckless.	0	1	2	3
2	I feel like I act totally on impulse.	0	1	2	3
3	Even though I know better, I can't stop making rash decisions.	0	1	2	3
4	I often feel like nothing I do really matters.	0	1	2	3
5	Others see me as irresponsible.	0	1	2	3
6	I'm not good at planning ahead.	0	1	2	3
7	My thoughts often don't make sense to others.	0	1	2	3
8	I worry about almost everything.	0	1	2	3
9	I get emotional easily, often for very little reason.	0	1	2	3
10	I fear being alone in life more than anything else.	0	1	2	3
11	I get stuck on one way of doing things, even when it's clear it won't work.	0	1	2	3
12	I have seen things that weren't really there.	0	1	2	3
13	I steer clear of romantic relationships.	0	1	2	3
14	I'm not interested in making friends.	0	1	2	3
15	I get irritated easily by all sorts of things.	0	1	2	3
16	I don't like to get too close to people.	0	1	2	3
17	It's no big deal if I hurt other peoples' feelings.	0	1	2	3
18	I rarely get enthusiastic about anything.	0	1	2	3
19	I crave attention.	0	1	2	3
20	I often have to deal with people who are less important than me.	0	1	2	3
21	I often have thoughts that make sense to me but that other people say are strange.	0	1	2	3
22	I use people to get what I want.	0	1	2	3
23	I often "zone out" and then suddenly come to and realize that a lot of time has passed.	0	1	2	3
24	Things around me often feel unreal, or more real than usual.	0	1	2	3
25	It is easy for me to take advantage of others.	0	1	2	3

First Name_____ Last Initial_____ Date_____ Therapist_____

Nicotine Use:

(1) Have you smoked at least 100 cigarettes in your entire life (NOTE: 5 packs = 100 cigarettes)?

(a) Yes
(b) No

IF NO, STOP
IF YES – PLEASE ANSWER BELOW

(2) Do you now smoke cigarettes every day, some days, or not at all?

(a) Every day
(b) Some days
(c) Not at all

(3) Think about your smoking during the last week, how many cigarettes did you smoke in an average day? (1 pack=20)

_____ cigarettes

(4) During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

(a) Yes
(b) No

(5) The last time you tried to quit, how long were you able to stop smoking?

_____ (circle: days, weeks, months, years)

(6) How long has it been since you last smoked a cigarette, even one or two puffs?

(a) Within the past month (less than 1 month ago)
(b) Within the past 3 months (1 month but less than 3 months ago)
(c) Within the past 6 months (3 months but less than 6 months ago)
(d) Within the past year (6 months but less than 1 year ago)
(e) Within the past 5 years (1 year but less than 5 years ago)
(f) Within the past 10 years (5 years but less than 10 years ago)
(g) 10 years or more

(7) Which of the following best describes you?

(a) "I don't want to stop smoking"
(b) "I think I should stop smoking but don't really want to"
(c) "I want to stop smoking but haven't thought about when"
(d) "I REALLY want to stop smoking but I don't know when I will"
(e) "I want to stop smoking and hope to soon"
(f) "I REALLY want to stop smoking and intend to in the next 3 months"
(g) "I REALLY want to stop smoking and intend to in the next month"

First Name_____ Last Initial_____ Date_____ Therapist_____

Alcohol Use:

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

(a) Never

(b) Monthly or less

(c) 2 to 4 times a month

(d) 2 to 3 times a week

(e) 4 to 5 times a week

(f) 6 or more times a week

(2) How many drinks did you have on a typical day when you were drinking in the past year?

(a) 0 drinks

(b) 1 to 2 drinks

(c) 3 to 4 drinks

(d) 5 to 6 drinks

(e) 7 to 9 drinks

(f) 10 or more drinks

(3) How often did you have 6 or more drinks on one occasion in the past year?

(a) never

(b) less than monthly

(c) monthly

(d) weekly

(e) daily or almost daily

First Name_____ Last Initial_____ Date_____ Therapist_____

In your **LIFETIME**, which of the following substances have you ever used? Check the box that applies:

SUBSTANCE	Yes	No
Cannabis (marijuana, pot, grass, hash, etc.)		
Cocaine (coke, crack, etc.)		
Prescription stimulants without a doctor's advice (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
Methamphetamine (speed, crystal meth, ice, etc.)		
Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
Sedatives or sleeping pills without a doctor's advice (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)		
Hallucinogens (LSD, acide, mushrooms, PCP, Special K, ecstacy, etc.)		
Street opioids (heroin, opium, etc.)		
Prescription opioids without a doctor's advice (fentanyl, oxycodone [Oxycontin, Percocet], hydrocodone [Vicoden], methadone, buprenorphine, etc.)		
Other – specify:		

In the **PAST 3 MONTHS**, how often have you used? Check the box that applies:

SUBSTANCE	Never	1-2 Times	Monthly	Weekly	Daily or Almost Daily
Cannabis (marijuana, pot, grass, hash, etc.)					
Cocaine (coke, crack, etc.)					
Prescription stimulants without a doctor's advice (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)					
Methamphetamine (speed, crystal meth, ice, etc.)					
Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)					
Sedatives or sleeping pills without a doctor's advice (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)					
Hallucinogens (LSD, acide, mushrooms, PCP, Special K, ecstacy, etc.)					
Street opioids (heroin, opium, etc.)					
Prescription opioids without a doctor's advice (fentanyl, oxycodone [Oxycontin, Percocet], hydrocodone [Vicoden], methadone, buprenorphine, etc.)					
Other – specify:					