Patient questionnaires:

Please fill out the following questionnaires and bring them to your appointment.

We are currently in the process of studying the program to evaluate whether it is an effective tool for stress and burnout recovery. All information will be kept confidential. No personal information will be used to identify your data. If you do not want to participate in the evaluation, please let Dr. Vaidya know. She will still need this information for your personal assessment.

Participant ID: _____ Date _____

Please answer as accurately as you can. Also, please feel free to ask me if you want any clarifications. This information will be kept confidential and any information used for data purposes will not link you to any of the information you provide.

1. Do you identify as (circle) male / female / other?

2. Age _____

3. Marital status (circle) Single Married Common-law Other partner Separated Divorced Widowed Other_____

4. a. Are you currently employed? (circle) Yes / No

   b. If employed, what type of work do you do? _____

   In the past **month**, have you missed any days of work due to illness or stress? (circle) Yes / No;

   If yes, how many days? _____

   c. If you are not currently employed, are you…. (please circle the most fitting) on disability? looking for employment? a caregiver? a student? retired? If yes, how many years? _____

5. My family's/household income level per year is (please circle one)

<$20,000 $20,000-50,000 $50,001-80,000 $80,001-120,000 >$120,000

6. My highest level of education is (please circle)

not graduated from high school high school college bachelor's master's doctorate post-doctorate

De Jong-Gierveld 6-point Loneliness Scale

1. I experience a general sense of emptiness
    a. Yes
    b. More or Less
    c. No

2. I miss having people around me
    a. Yes
    b. More or Less
    c. No

3. I often feel rejected
    a. Yes
    b. More or Less
    c. No

4. There are plenty of people I can rely on when I have problems
    a. Yes
    b. More or Less
    c. No

5. There are many people I can trust completely
    a. Yes
    b. More or Less
    c. No

6. There are enough people I feel close to
    a. Yes
    b. More or Less
    c. No

Scoring

1-3 Response Score Yes 1, More or less 1, No 0

4-6 Response Score Yes 0, More or less 1, No 1

The Rivermead Post-Concussion Symptoms Questionnaire

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident.

For each one, please circle the number closest to your answer.

0 = Not experienced at all
1 = No more of a problem
2 = A mild problem
3 = A moderate problem
4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:	0	1	2	3	4
Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4
Total					

Are you experiencing any other difficulties?

1. _____ 0 1 2 3 4

2. _____ 0 1 2 3 4

Insomnia Severity Index

(from Charles M. Morin, PhD, Universite Laval).

Please rate the current (ie last 2 weeks) severity of your insomnia problems:

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

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 (eg. Daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc) CURRENTLY?

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

Total Score: _____

Total Score Categories:
0-7 – No clinical significant Insomnia
8-14 - Sub-threshold Insomnia
15-21 – Clinical Insomnia (moderate severity)
22-28 – Clinical Insomnia (Severe)

Perceived Stress Scale

Adapted from Cohen, S. (1994) Perceived Stress Scale

This is a measure of the degree to which you are experiencing stress in your various life situations. For each item, choose the number that best describes you by choosing one of the five boxes to the right of the statement according to the following scale:

In the last month, how often have you …	0 = never	1 = Almost never	2 = sometimes	3 = fairly often	4 = very often
1. been upset because of something that happened unexpectedly?					
2. felt that you were unable to control the important things in life?					
3. felt nervous or "stressed"?					
4. felt confident about your ability to handle your personal problems					
5. felt that things were going your way?					
6. found that you could not cope with all the things that you had to do?					
7. been able to control irritations in your life?					
8. Have you felt that you were on top of things.					
9. been angered because of things that were outside of your control?					
10. felt difficulties were piling up so high that you could not overcome them?					

Total score:

Sheehan Disability Scale

This validated scale assess the impact of the burnout, panic, anxiety, phobia, or depressive symptoms on three major sectors in life - work/school, social life, and family/home responsibilities

Work/School -The symptoms have disrupted your work/school work:

Not at all	Mildly			Moderately			Markedly			Extremely
0	1	2	3	4	5	6	7	8	9	10

Social Life – The symptoms =have disrupted your social life/leisure activities

Not at all	Mildly			Moderately			Markedly			Extremely
0	1	2	3	4	5	6	7	8	9	10

Family Life/Home Responsibilities

Not at all	Mildly			Moderately			Markedly			Extremely
0	1	2	3	4	5	6	7	8	9	10

DAYS LOST – On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? _____

DAYS UNPRODUCTIVE - On how many days in the last week did you feel so impaired by your symptoms that even though you went to school or work, your productivity was reduced? _____

GAD – 7

During the last 2 weeks, how often have you been bothered by the following problems?

Problem	Not at all 0	Several days 1	More then half of the days 2	Nearly every day 3
1. Feeling nervous, anxious, or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				
Total each column				
Total Score				

If you checked off any problems, 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 difficult at all Somewhat difficult Very Difficult Extremely Difficult

Scoring: Mild Anxiety 5-9 Moderate anxiety 10-14 Severe Anxiety 15-21

Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half of the days 2	Nearly every Day 3
1. Little Interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things such as reading the newspaper, or watching TV				
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				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
ADD COLUMNS				
TOTAL SCORE				

10. If you checked off ANY problems, 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 Difficult at all **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

SELF-COMPASSION SCALE–Short Form (SCS–SF 2)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering.

Answer the following on a scale of 1- 5, with (1) ALMOST NEVER to (5) ALMOST ALWAYS

_____2. I try to be understanding and patient towards those aspects of my personality I don't like.

_____3. When something painful happens I try to take a balanced view of the situation.

_____5. I try to see my failings as part of the human condition.

_____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____7. When something upsets me I try to keep my emotions in balance.

_____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

Answer the following on a scale from 1- 5,with (1) ALMOST ALWAYS to (5) ALMOST NEVER (the scale is reversed).

_____1. When I fail at something important to me I become consumed by feelings of inadequacy.

_____4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____8. When I fail at something that's important to me, I tend to feel alone in my failure

_____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____11. I'm disapproving and judgmental about my own flaws and inadequacies.

_____12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Readiness for Change

How important is it for you to make a change?

0-1-2-3-4-5-6-7-8-9-10

How Confident are you about making this change?

0-1-2-3-4-5-6-7-8-9-10

How ready are you to make this change?

0-1-2-3-4-5-6-7-8-9-10

Follow up questions:

Why are you at your current score and not zero?

What would it take for you to get to a higher score?

ADVERSE CHILDHOOD EXPERIENCE SCORE

The Adverse Childhood Experience (ACE) Score was developed by Dr. Vincent Fellitti at Kaiser Permanente in San Diego California in conjunction with Center for Disease Control (CDC) in Atlanta Georgia. It was first published in 1997.

Results showed adult patients who experienced higher stress/adverse experiences in childhood, had higher incidences of Depression and Anxiety (correlated with ACE score of 2 or higher), and Chronic Illness (correlated with score of 4 or higher). We are now screening them in the Medical Field, to identify those who are at risk for chronic illness, so we can help people make changes earlier.

For more information on the ACE score, check out the following links:

https://www.acesconnection.com/blog/got-your-ace-resilience-scores

Watch the TED TALK by Dr. Nadine Burke Harris:

https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en

The ACE Questionnaire follows. It asks sensitive and private questions about your childhood. You may never have discussed these events with anyone. If you feel filling out this score may trigger you, please wait until your assessment with Dr. Vaidya

Adverse Childhood Experience Score

While you were growing up, during your first 18 years of life:
Answer: NO = 0, Yes = 1

1. Did a parent or other adult in the household often or very often swear at you, insult you, put you down, or humiliate you? OR act in a way that made you afraid that you might be physically hurt?	
2. Did a parent or other adult in the household often or very often push, grab, slap, or throw something at you? OR did they ever hit you so hard that you had marks or were injured?	
3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? OR did they ever attempt or actually have oral, anal, or vaginal intercourse with you?	
4. Did you often or very often feel that no one in your family loved you or thought you were important or special? OR did you feel that your family didn't look out for each other, feel close to each other, or support each other?	
5. Did you often or very often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? OR that your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	
6. Were your parents ever separated or divorced?	
7. Was your mother or stepmother often or very often pushed, grabbed, slapped, or had something thrown at her? OR sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? OR ever repeatedly hit at least a few minutes or threatened with a gun or knife?	
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?	
10. Did a household member go to prison?	

Now add up your "Yes" answers: _____ This is your ACE Score.

RESILIENCE Questionnaire

To be completed after completing the ACE Score. **Please circle the most accurate answer under each statement:**

1.I believe that my mother loved me when I was little.
Definitely true Probably true Not sure Probably Not True Definitely Not True

2. I believe that my father loved me when I was little.
Definitely true Probably true Not sure Probably Not True Definitely Not True

3. When I was little, other people helped my mother and father take care of me and they seemed to love me.
Definitely true Probably true Not sure Probably Not True Definitely Not True

4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.
Definitely true Probably true Not sure Probably Not True Definitely Not True

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.
Definitely true Probably true Not sure Probably Not True Definitely Not True

6. When I was a child, neighbors or my friends' parents seemed to like me.
Definitely true Probably true Not sure Probably Not True Definitely Not True

7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.
Definitely true Probably true Not sure Probably Not True Definitely Not True

8. Someone in my family cared about how I was doing in school.
Definitely true Probably true Not sure Probably Not True Definitely Not True

9. My family, neighbors and friends talked often about making our lives better.
Definitely true Probably true Not sure Probably Not True Definitely Not True

10. We had rules in our house and were expected to keep them.
Definitely true Probably true Not sure Probably Not True Definitely Not True

11. When I felt really bad, I could almost always find someone I trusted to talk to.
Definitely true Probably true Not sure Probably Not True Definitely Not True

12. As a youth, people noticed that I was capable and could get things done.
Definitely true Probably true Not sure Probably Not True Definitely Not True

13. I was independent and a go-getter.
Definitely true Probably true Not sure Probably Not True Definitely Not True

14. I believed that life is what you make it.
Definitely true Probably true Not sure Probably Not True Definitely Not True

How many of these 14 protective factors did I have as a child and youth? (How many of the 14 were circled "Definitely True" or "Probably True"?) _____

Of these circled, how many are still true for me? _____