

CORE-10

IMPORTANT - PLEASE READ THIS FIRST This form has 10 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this.

Client ID: _____ Age: _____

Gender

☐ M ☐ F

Date form completed: _____ dd / mm / yyyy

I have felt tense, anxious or nervous

- ☐ Not at all
☐ Only occasionally
☐ Sometimes
☐ Often
☐ Most or all of the time

I have felt I have someone to turn to for support when needed

- ☐ Not at all
☐ Only occasionally
☐ Sometimes
☐ Often
☐ Most or all of the time

I have felt able to cope when things go wrong

- ☐ Not at all
☐ Only occasionally
☐ Sometimes
☐ Often
☐ Most or all of the time

Talking to people has felt too much for me

- ☐ Not at all
☐ Only occasionally
☐ Sometimes
☐ Often
☐ Most or all of the time

I have felt panic or terror

- ☐ Not at all
☐ Only occasionally
☐ Sometimes
☐ Often
☐ Most or all of the time

I made plans to end my life

- ☐ Not at all
☐ Only occasionally
☐ Sometimes
☐ Often
☐ Most or all of the time

I have had difficulty getting to sleep or staying asleep

- ☐ Not at all
- ☐ Only occasionally
- ☐ Sometimes
- ☐ Often
- ☐ Most or all of the time

I have felt despairing or hopeless

- ☐ Not at all
- ☐ Only occasionally
- ☐ Sometimes
- ☐ Often
- ☐ Most or all of the time

I have felt unhappy

- ☐ Not at all
- ☐ Only occasionally
- ☐ Sometimes
- ☐ Often
- ☐ Most or all of the time

Unwanted images or memories have been distressing me

- ☐ Not at all
- ☐ Only occasionally
- ☐ Sometimes
- ☐ Often
- ☐ Most or all of the time

Total (Clinical Score*): _____