We're listening to you.

We value the information from you about how you are feeling and how you are coping with everyday activities.

You can help by filling in the simple questionnaire that is attached.

There are no right or wrong answers, just choose the response that best shows how you feel.

Helping us with these questions is optional and please be assured that if you choose not to complete this questionnaire, it will in no way prejudice the relationship with your treatment team.

The information will be kept confidential and only used to look at how you are feeling and to help us plan better health services.

Insert health unit logo here	NOCC Assessment Consumer Self-Report **K10+**	Unit Record No: _____ CME Number: _____

Instructions for the consumer.

The following ten questions ask about how you have been feeling in the last four weeks. For each question, mark the circle under the option that best describes the amount of time you felt that way.

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
1.	In the last four weeks, about how often did you feel tired out for no good reason?	O	O	O	O	O
2.	In the last four weeks, about how often did you feel nervous?	O	O	O	O	O
3.	In the last four weeks, about how often did you feel so nervous that nothing could calm you down?	O	O	O	O	O
4.	In the last four weeks, about how often did you feel hopeless?	O	O	O	O	O
5.	In the last four weeks, about how often did you feel restless or fidgety?	O	O	O	O	O
6.	In the last four weeks, about how often did you feel so restless you could not sit still?	O	O	O	O	O
7.	In the last four weeks, about how often did you feel depressed?	O	O	O	O	O
8.	In the last four weeks, about how often did you feel that everything was an effort?	O	O	O	O	O
9.	IN the last four weeks, about how often did you feel so sad that nothing could cheer you up?	O	O	O	O	O
10.	In the last four weeks, about how often did you feel worthless?	O	O	O	O	O

The next few questions are about how these feelings may have affected you in the last four weeks.

You need not answer these questions if you answered “None of the time” to all of the ten questions about your feelings.

11.	In the last four weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings?	_____ (Number of Days, 0-28)
12.	Aside from those days, in the last 4 weeks, HOW MANY DAYS were you able to work or study of manage your day to day activities, but had to CUT DOWN on what you did because of these feelings?	_____ (Number of Days, 0-28)
13.	In the last 4 weeks, how many times have you seen a doctor or any other health professional about these feelings?	_____ (Number of Times)

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
14..	In the last 4 weeks, how often have physical health problems been the main cause of these feelings?	O	O	O	O	O

Thank-you for completing this questionnaire.
Please return it to the staff member who asked you to complete it.

FOR OFFICE USE ONLY

Collection Point

Service Unit…… Service Unit Code [ ] [ ] [ ] [ ] [ ] [ ]

Staff Member (Print Name)……..……Sign……..……

Designation……Contact Date (date offered) __ __ / __ __ / __ __ __ __

Mental Health Service Setting *(please circle one only)*

Inpatient ……. 01 Community Residential …….02 Ambulatory …….03

Reason for Collection (Collection Occasion) *(please circle one only)*

Admission	Review	Discharge
New Referral 01	Three Month Review 04	No Further Care 06
Admitted from other treatment setting 02	Review – Other 05	Discharge to change of treatment setting 07
Admission – Other 03		Death 08
		Discharge – Other 09

Collection Status *(please circle one only)*

Complete or partially complete 01

Not completed due to temporary contraindication 02

Not completed due to general exclusion 03

Not completed due to refusal by consumer 04