Southwest Iowa Families, Inc.
215 E. Washington St., Clarinda, IA 51632
Phone: (712) 542-3501 Fax: (712) 542-4725

Adult Client Stress Questionnaire

Client's Name: **Client's DOB:** **Title 19#:**

We ask all of our clients age 18 & older, complete this form. For each question below circle the number that best reflects how you feel and check any boxes that apply to you.

Over the last **two weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. ☐ Trouble falling or staying asleep, or ☐ sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. ☐ Poor appetite or ☐ overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. ☐ Moving or speaking so slowly that people could have noticed. Or the opposite- ☐ being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
10. Feeling nervous, anxious, or on edge	0	1	2	3
11. Not being able to sleep or control worrying	0	1	2	3
12. Worrying too much about different things	0	1	2	3
13. Trouble relaxing	0	1	2	3
14. Being so restless that it is hard to sit still	0	1	2	3
15. Becoming easily annoyed or irritable	0	1	2	3
16. Feeling afraid, as if something awful might happen	0	1	2	3

Smith, P.H., Earp, J.A., & DeVellis, R. (1995), Development and validation of the Women's Experience with Battering (WEB) Scale, Women's Health 1, 273-288

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In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the **past month**, you

1. Have had nightmares about it or thought about it when you did not want to?	No	Yes
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	No	Yes
3. Were constantly on guard, watchful, or easily startled?	No	Yes
4. Felt numb or detached from others, activities, or your surroundings?	No	Yes

In the last **12 months**,

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	No	Yes
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care?	No	Yes
3. Has anyone prevented you from being with people you wanted to be with?	No	Yes
4. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	No	Yes
5. Has anyone tried to force you to sign papers or to use your money against your will?	No	Yes
6. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	No	Yes

In your **life**,

1. Have you ever felt you ought to cut down on your drinking or drug use?	Yes	No
2. Have people annoyed you by criticizing your drinking or drug use?	Yes	No
3. Have you ever felt bad or guilty about your drinking or drug use?	Yes	No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	Yes	No

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Do you feel like your childhood met your needs? How or why not? Yes No

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