

CLINICAL OUTCOMES in ROUTINE EVALUATION

CORE-10 Screening Measure

Site ID	<input type="text"/>	Stage Completed
Client ID	<input type="text"/> / <input type="text"/>	S Screening
	letters only numbers only	R Referral
Sub codes	<input type="text"/> / <input type="text"/> / <input type="text"/>	A Assessment
	Therapist ID numbers only (1) numbers only (2)	F First Therapy Session
Date form given	<input type="text"/> / <input type="text"/> / <input type="text"/>	P Pre-therapy (unspecified)
	D D M M Y Y Y Y	D During Therapy
		L Last therapy session
		X Follow up 1
		Y Follow up 2
		Episode <input type="text"/> Stage <input type="text"/>
		Gender
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
		Age <input type="text"/>

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.

Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week...

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

	0	1	2	3	4
1 I have felt tense, anxious or nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 I have felt I have someone to turn to for support when needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 I have felt I have a problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Talking to people has felt too much for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 I have felt panic or terror	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 I made plans to end my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 I have felt despairing or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 I have felt I have a problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Unwanted images or memories have been distressing me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total (Clinical Score*)

*** Procedure:** Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score.

Quick method for the CORE-10 (if all items completed): Add together the item scores to get the Clinical Score.

Thank you for your time in completing this questionnaire

CORE-10 Copyright CORE System Trust (February 2006)

DEACTIVATED