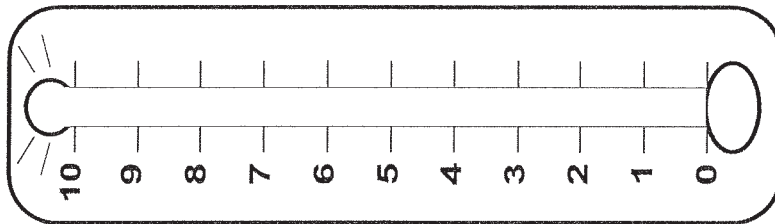


Distress Management

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Extreme distress

No distress



Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES NO Practical Problems

- YES NO Child care
- YES NO Housing
- YES NO Insurance/financial
- YES NO Transportation
- YES NO Work/school

Family Problems

- Dealing with children
- Dealing with partner

Emotional Problems

- Depression
- Fears
- Nervousness
- Sadness
- Worry
- Loss of interest in usual activities

YES NO Physical Problems

- YES NO Appearance
- YES NO Bathing/dressing
- YES NO Breathing
- YES NO Changes in urination
- YES NO Constipation
- YES NO Diarrhea
- YES NO Eating
- YES NO Fatigue
- YES NO Feeling Swollen
- YES NO Fevers
- YES NO Getting around
- YES NO Indigestion
- YES NO Memory/concentration
- YES NO Mouth sores
- YES NO Nausea
- YES NO Nose dry/congested
- YES NO Pain
- YES NO Sexual
- YES NO Skin dry/itchy
- YES NO Sleep
- YES NO Tingling in hands/feet

Other Problems: _____