CORE Professional Services, P.A.

WCP Questionnaire (Adult)

Private and Confidential

Last Name:	First Name:	Date:

WHODAS QUESTIONNAIRE 2.0

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, or problems with alcohol or drugs. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:					
Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
Learning a new task, for example learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
How much of a problem did you have joining in community activities (for example, festivities, religious, or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

In the past 30 days, how much difficulty did you have in:					
Concentrating on doing something for ten minutes	None	Mild	Moderate	Severe	Extreme or cannot do
Walking a long distance such as a mile (or equivalent)?	None	Mild	Moderate	Severe	Extreme or cannot do
Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do

Overall, in the past 30 days, how many days were these difficulties present?	**Record number of days _____**
In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health conditions?	**Record number of days _____**
In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health conditions?	**Record number of days _____**

CAGE-AID Questionnaire

Have you ever felt you had to cut down on your drinking or drug use?	____Yes ____No
Have you ever had people annoy you by criticizing your drinking or drug use?	____Yes ____No
Have you ever felt bad or guilty about your drinking or drug use?	____Yes ____No
Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started?	____Yes ____No

Treatment Goals

What I hope to change by coming here is:_____
_____
_____

How do you feel about the issue that brought you in: _____
_____
_____

Current Problem Checklist

As you are filling this out please remember you do not need to experience these symptoms every day. The symptoms may present themselves when you are having a problematic day or period of time.
NOTE: If your answer is sometimes, circle YES and explain how often this symptom occurs.

Changes in sleeping pattern:	**YES / NO**	_____
Energy Level:	**YES / NO**	_____
Interest in pleasures:	**YES / NO**	_____
Appetite-Weight loss/gain:	**YES / NO**	_____
Depressed, Despondent, Sad:	**YES / NO**	_____
Social withdrawal/Isolating:	**YES / NO**	_____
Deterioration of personal hygiene:	**YES / NO**	_____
Feeling hopeless/helpless/worthless:	**YES / NO**	_____
Feeling guilty:	**YES / NO**	_____
Trouble concentrating:	**YES / NO**	_____
Lacking motivation:	**YES / NO**	_____
Constant worrying:	**YES / NO**	_____
Memory difficulty:	**YES / NO**	_____
Euphoria:	**YES / NO**	_____
Irritability/Feeling angry:	**YES / NO**	_____
Decreased need for sleep:	**YES / NO**	_____
Flight of Ideas:	**YES / NO**	_____
Grandiosity:	**YES / NO**	_____
Hyperverbal:	**YES / NO**	_____
Racing Thoughts:	**YES / NO**	_____

High-Risk Behavior:	**YES / NO**	_____
Mood Swings:	**YES / NO**	_____
Increased psychomotor activities:	**YES / NO**	_____
Motor Activity:	**YES / NO**	_____
Short Attention Span:	**YES / NO**	_____
Distractibility:	**YES / NO**	_____
Impulsivity:	**YES / NO**	_____
Uncontrollable Worry:	**YES / NO**	_____
Nervous/On Edge:	**YES / NO**	_____
Easily Fatigued:	**YES / NO**	_____
Muscle Tension/Restlessness:	**YES / NO**	_____
Panic Attacks (describe):	**YES / NO**	_____
Obsessive-Compulsive Thoughts:	**YES / NO**	_____
Obsessive-Compulsive Behaviors:	**YES / NO**	_____
PTSD Symptoms:	**YES / NO**	_____
Phobias:	**YES / NO**	_____
Somatic Symptoms:	**YES / NO**	_____
Visual/Auditory Hallucinations:	**YES / NO**	_____
Tactile/Olfactory Hallucinations:	**YES / NO**	_____
Command Hallucinations:	**YES / NO**	_____
Delusions:	**YES / NO**	_____
Paranoid Ideations:	**YES / NO**	_____
Other:	**YES / NO**	_____
Increased/Decreased Appetite:	**YES / NO**	_____
Binging:	**YES / NO**	_____
Purging:	**YES / NO**	_____
Weight Loss/Gain in the last month:	**YES / NO**	_____
Distorted Body Image:	**YES / NO**	_____
Legal Issues, Past or Present:	**YES / NO**	_____
Poor Impulse Control:	**YES / NO**	_____
Anger Control Problems:	**YES / NO**	_____
Violence toward Others:	**YES / NO**	_____
Destruction of Property:	**YES / NO**	_____
Less Interested in Friends and Family	**YES / NO**	_____
Problems at Work/School:	**YES / NO**	_____
Problems in Relationships:	**YES / NO**	_____
Find Rules Hard to Follow:	**YES / NO**	_____
Difficulty in Social Situations:	**YES / NO**	_____
Other:	**YES / NO**	_____

Answers on this form may be changed post diagnostic assessment based on information the client provides in the interview.