

Government Performance and Results Act (GPRA) Client  
Outcome Measures for Discretionary Programs

Revised (2019) for OhioMHAS First Episode Psychosis  
Information System (FEPIS)

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## Overview

This form was created to compliment the GPRA baseline, follow up and discharge forms in the FEPIS. Both the FEPIS tool and this paper version were adapted from the SAMHSA CSAT GPRA client outcome assessment tool. Consumer data collected on this form should also be recorded in the FEPIS.

### A. Record Management

<b>Consumer ID</b>	<i>Generated from entry of the consumer first and last name</i>	
	<b>(F.LAST)</b>	

<b>Clinician Name</b>	<i>Up to four clinicians may be entered into text boxes with their appropriate roles (psychiatrist, case manager, counselor, nurse)</i>	
	<b>Role</b>	<b>Name</b>

<b>Completed By</b>	<b>Name</b>	
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<b>Interview Date</b>	<b>Month</b>	<b>Day</b>	<b>Year</b>

<b>Enrollment Date</b>	<b>Month</b>	<b>Day</b>	<b>Year</b>

<b>Did the client sign the consent form?</b>	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>

<b>A1a. Insurance</b>	<i>Place an 'X' mark in the appropriate box; or specify 'other'</i>				
	<b>Medicare</b>	<b>Medicaid</b>	<b>Private Insurance</b>	<b>Uninsured</b>	<b>Other (Specify)</b>

<b>A1b. Approximate date of onset of psychosis</b>	<b>Month</b>	<b>Day</b>	<b>Year</b>

<b>A1c. Diagnosis</b>	<i>Include up to 4 mental health diagnoses including psychotic disorders</i>	
	<b>Diagnosis 1</b>	
	<b>Diagnosis 2</b>	
	<b>Diagnosis 3</b>	
	<b>Diagnosis 4</b>	

<b>A1d. Use of antipsychotic medication</b>	<i>Mark appropriate yes or no box with an 'X'; along with the corresponding medication from the list; or specify 'other'</i>			
	<b>Yes</b>		<b>No</b>	
		<b>Aripiprazole (Abilify)</b>		
		<b>Asenapine (Saphris)</b>		
		<b>Brexpiprazole (Rexulti)</b>		
		<b>Chlorpromazine (Largactil, Thorazine)</b>		
		<b>Clozapine (Clozaril)</b>		
		<b>Fluphenazine (Prolixin)</b>		
		<b>Haloperidol (Haldol)</b>		
		<b>Loxapine (Loxitane)</b>		
		<b>Lurasidone (Latuda)</b>		
		<b>Olanzapine (Zyprexa, Ozace)</b>		

		Paliperidone (Invega)
		Perphenazine (Trilafon)
		Quetiapine (Seroquel)
		Risperidone (Risperdal, Zepidone)
		Ziprasidone (Geodon, Zeldox)
		Other
	Specify	

<b>A1d.1. Was a Long-Acting Injectable (LAI) used to administer any of the antipsychotic medicines selected in question 1d?</b>	<i>Mark the appropriate category with an 'X' for the medications listed below if they were selected in question 1d; skip if response to question 1d was 'no'</i>	
		Aripiprazole (Abilify)
		Fluphenazine (Prolixin)
		Haloperidol (Haldol)
		Olanzapine (Zyprexa, Ozace)
		Other
		No

<b>A1e. Is the individual on other psychiatric medications?</b>	<i>Mark the appropriate box with an 'X'; if 'Yes', please specify</i>	
		No
		Yes
	Specify	

<b>A1f. Do you feel medication is helpful?</b>	<i>Mark the appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>
<input type="checkbox"/>	<b>Unsure</b>	

<b>A1. What is your gender?</b>	<i>Mark the appropriate box with an 'X'; if "other", please specify</i>	
	<input type="checkbox"/>	<b>Male</b>
	<input type="checkbox"/>	<b>Female</b>
	<input type="checkbox"/>	<b>Transgender</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Other</b>
<input type="checkbox"/>	<b>Specify</b>	

<b>A2. Are you Hispanic or Latino?</b>	<i>Mark the appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>
<input type="checkbox"/>	<b>Refused</b>	

<b>A3. What is your race?</b>	<i>Mark the appropriate box with an 'X'</i>				
		<b>Race</b>	<b>Yes</b>	<b>No</b>	<b>Refused</b>
	<b>i.</b>	<b>Black or African American</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>ii.</b>	<b>Asian</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>iii.</b>	<b>Native Hawaiian/Other Pacific Islander</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>iv.</b>	<b>Alaska Native</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>v.</b>	<b>White</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>vi.</b>	<b>American Indian</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>A4. Client date of birth</b>	<b>Month</b>	<b>Year</b>

<b>A5. Have you ever served in the Armed Forces, in the Reserves, or in the National Guard?</b>	<i>Mark the appropriate category with an 'X'</i>	
		No
		Yes, in the Armed Forces
		Yes, in the Reserves
		Yes, in the National Guard
		Refused
		Don't Know

<b>A5a. Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard?</b>	<i>Mark the appropriate category with an 'X'</i>	
		No, separated or retired from the Armed Forces, Reserves or National Guard
		Yes, in the Armed Forces
		Yes, in the Reserves
		Yes, in the National Guard
		Refused
		Don't know

<b>A5b. Have you ever been deployed to a combat zone?</b>	<i>Mark the appropriate category with an 'X'</i>	
		Never deployed
		Deployed
		Refused
	Don't know	

<b>A5b.1. Combat Zone</b>	<i>Mark the appropriate category with an 'X' for ALL THAT APPLY if response to question 5b is 'deployed'; skip for all other responses to question 5b</i>	
		<b>Iraq or Afghanistan (e.g. OEF/OIF/OND)</b>
		<b>Persian Gulf (Operation Desert Shield/Desert Storm)</b>
		<b>Vietnam/Southeast Asia</b>
		<b>Korea</b>
		<b>WWII</b>
		<b>Deployed to a combat zone not listed above (e.g. Bosnia/Somalia)</b>

## A2. Record Management – Planned Services

<b>What services did you provide?</b>	<i>Mark either 'Yes' or 'No' for each item with an 'X'; if 'other' please specify</i>		
	<b>Modality</b>	<b>Yes</b>	<b>No</b>
	<b>1. Case Management</b>		
	<b>2. Day Treatment</b>		
	<b>3. Inpatient/Hospital (Other than Detox)</b>		
	<b>4. Outpatient</b>		
	<b>5. Outreach</b>		
	<b>6. Intensive Outpatient</b>		
	<b>7. Methadone</b>		
	<b>8. Residential/Rehabilitation</b>		
	<b>9. Detoxification (Select only one)</b>		
	<b>A. Hospital Inpatient</b>		
	<b>B. Free Standing Residential</b>		
	<b>C. Ambulatory Detoxification</b>		
<b>10. After Care</b>			

	<b>11. Recovery Support</b>		
	<b>12. Other</b>		
	<b>Specify</b>		

<b>Treatment Services</b>	<i>Mark either 'Yes' or 'No' for each item with an 'X'; if 'other' please specify</i>		
	<b>Modality</b>	<b>Yes</b>	<b>No</b>
	<b>1. Screening</b>		
	<b>2. Brief Intervention</b>		
	<b>3. Brief Treatment</b>		
	<b>4. Referral to Treatment</b>		
	<b>5. Assessment</b>		
	<b>6. Treatment/Recovery/Planning</b>		
	<b>7. Individual Counseling</b>		
	<b>8. Group Counseling</b>		
	<b>9. Family/Marriage Counseling</b>		
	<b>10. Co-Occuring Treatment/Recovery Services</b>		
	<b>11. Pharmacological Interventions</b>		
	<b>12. HIV/AIDS Counseling</b>		
	<b>13. Other Clinical Services</b>		
<b>Specify</b>			

<b>Case Management Services</b>	<i>Mark either 'Yes' or 'No' for each item with an 'X'; if 'other' please specify</i>		
	<b>Modality</b>	<b>Yes</b>	<b>No</b>
	<b>1. Family Services (Including Marriage Education, Parenting, &amp; Child Development Services)</b>		
	<b>2. Child Care</b>		
	<b>3. Employment Service</b>		
	<b>A. Pre-employment</b>		
	<b>B. Employment Coaching</b>		
	<b>4. Individual Services Coordination</b>		
	<b>5. Transportation</b>		
	<b>6. HIV/AIDS Services</b>		
	<b>7. Supportive Transitional Drug-Free Housing Services</b>		
	<b>8. Other</b>		
	<b>Specify</b>		

<b>Medical Services</b>	<i>Mark either 'Yes' or 'No' for each item with an 'X'; if 'other' please specify</i>		
	<b>Modality</b>	<b>Yes</b>	<b>No</b>
	<b>1. Medical Care</b>		
	<b>2. Alcohol/Drug Testing</b>		
	<b>3. HIV/AIDS Medical Support &amp; Testing</b>		
	<b>4. Other Medical Services</b>		
<b>Specify</b>			

<b>After Care Services</b>	<i>Mark either 'Yes' or 'No' for each item with an 'X'; if 'other' please specify</i>		
	<b>Modality</b>	<b>Yes</b>	<b>No</b>
	1. Continuing Care		
	2. Relapse Prevention		
	3. Recovery Coaching		
	4. Self-Help and Support Group		
	5. Spiritual Support		
	6. Other After Care Services		
<b>Specify</b>			

<b>Education Services</b>	<i>Mark either 'Yes' or 'No' for each item with an 'X'; if 'other' please specify</i>		
	<b>Modality</b>	<b>Yes</b>	<b>No</b>
	1. Substance Abuse Education		
	2. HIV/AIDS Education		
	3. Other Education Services		
<b>Specify</b>			

<b>Peer-to-Peer Recovery Support Services</b>	<i>Mark either 'Yes' or 'No' for each item with an 'X'; if 'other' please specify</i>		
	<b>Modality</b>	<b>Yes</b>	<b>No</b>
	1. Peer Coaching or Mentoring		
	2. Housing Support		
	3. Alcohol and Drug-Free Social Activities		
	4. Information and Referral		
	5. Other Peer-to-Peer Recovery Support Services		
<b>Specify</b>			

## B. Drug and Alcohol Use

<b>B1a. During the Past 6 months, have you used any alcohol?</b>	<i>Mark either 'Yes' or 'No' with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>

<b>B1a.1. During the past 30 days, how many days have you used alcohol?</b>	<i>Record the number of days reported; or mark 'refused' or 'don't know' with an 'X'; skip if response to question B1a is 'No'</i>				
	<input type="checkbox"/>	<b># of Days</b>	<input type="checkbox"/>	<b>Refused</b>	<input type="checkbox"/>

<b>B1b. During the past 6 months, have you used any alcohol to intoxication?</b>	<i>Mark either 'Yes' or 'No' with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>

<b>B1b.1. During the past 30 days, how many days have you used alcohol to intoxication? (5+ drinks in one sitting)</b>	<i>Record the number of days reported; or mark 'refused' or 'don't know' with an 'X'; skip if response to question B1b is 'No'</i>				
	<input type="checkbox"/>	<b># of Days</b>	<input type="checkbox"/>	<b>Refused</b>	<input type="checkbox"/>

<b>B1c. During the past 6 months, have you used any illegal drugs?</b>	<i>Mark either 'Yes' or 'No' with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>

<b>B1c.1. During the past 30 days, how many days have you used illegal drugs?</b>	<i>Record the number of days reported; or mark 'refused' or 'don't know' with an 'X'; skip if response to question B1c is 'No'</i>				
	<input type="checkbox"/>	<b># of Days</b>	<input type="checkbox"/>	<b>Refused</b>	<input type="checkbox"/>

<b>B1d. During the past 6 months, have you used both alcohol and drugs?</b>	<i>Mark either 'Yes' or 'No' with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>

<b>B1d.1. During the past 30 days, how many days have you used both drugs and alcohol (on the same day)</b>	<i>Record the number of days reported; or mark 'refused' or 'don't know' with an 'X'; skip if response to question B1c is 'No'</i>				
		<b># of Days</b>		<b>Refused</b>	<b>Don't Know</b>

<b>B3. During the past 6 months, have you injected drugs?</b>	<i>Mark either 'Yes' or 'No' with an 'X'</i>	
		<b>Yes</b>
		<b>No</b>
		<b>Refused</b>
	<b>Don't know</b>	

<b>B3a. Current tobacco use?</b>	<i>Mark either 'Yes' or 'No' with an 'X'</i>	
		<b>Yes</b>
	<b>No</b>	

### C. Family and Living Conditions

<b>C1. In the past 6 months, where have you been living most of the time?</b>  <b>[DO NOT READ RESPONSE OPTIONS TO CLIENT]</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Shelter (Safe Havens, Transitional Living Center [TLC], Low-Demand Facilities, Reception Centers, Other Temporary Day or Evening Facility)</b>
	<input type="checkbox"/>	<b>Street/Outdoors (Sidewalk, Doorway, Park, Public or Abandoned Building)</b>
	<input type="checkbox"/>	<b>Institution (Hospital, Nursing Home, Jail/Prison)</b>
	<input type="checkbox"/>	<b>Parents House</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Don't Know</b>

<b>C1a. Was this person homeless at any time during the past 6 months?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>

<b>C2. During the past 6 months, how stressful have things been for you because of your use of alcohol or other drugs?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Not at all</b>
	<input type="checkbox"/>	<b>Somewhat</b>
	<input type="checkbox"/>	<b>Considerably</b>
	<input type="checkbox"/>	<b>Extremely</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Don't Know</b>

<b>C3. During the past 6 months, has your use of alcohol or other drugs caused you to reduce or give up important activities?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Not at all</b>
	<input type="checkbox"/>	<b>Somewhat</b>
	<input type="checkbox"/>	<b>Considerably</b>
	<input type="checkbox"/>	<b>Extremely</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Don't Know</b>

<b>C4. During the past 6 months, has your use of alcohol or other drugs caused you to have emotional problems?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Not at all</b>
	<input type="checkbox"/>	<b>Somewhat</b>
	<input type="checkbox"/>	<b>Considerably</b>
	<input type="checkbox"/>	<b>Extremely</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Don't Know</b>

<b>C5. Are you currently pregnant?</b>  <b>[IF NOT MALE]</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Don't Know</b>

<b>C6. Do you have children?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Don't Know</b>

<b>C6a. How many children do you have?</b>	<i>Record the number reported; or mark 'refused' or 'don't know' with an 'X'; skip if response to question B1c is 'No', 'Refused', or 'Don't know'</i>				
	<input type="checkbox"/>	<b># of Children</b>	<input type="checkbox"/>	<b>Refused</b>	<input type="checkbox"/>

<b>C6b. Are any of your children living with someone else due to a child protection court order?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Don't know</b>

<b>C6c. How many of your children are living with someone else due to a child protection court order?</b>	<i>Record the number reported; or mark 'refused' or 'don't know' with an 'X'; skip if response to question B1c is 'No', 'Refused', or 'Don't know'</i>				
	<input type="checkbox"/>	<b># of Children</b>	<input type="checkbox"/>	<b>Refused</b>	<input type="checkbox"/>

<b>C6d. For how many of your children have you lost parental rights? [THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED]</b>	<i>Record the number reported; or mark 'refused' or 'don't know' with an 'X'; skip if response to question B1c is 'No', 'Refused', or 'Don't know'</i>				
	<input type="checkbox"/>	<b># of Children</b>	<input type="checkbox"/>	<b>Refused</b>	<input type="checkbox"/>

## D. Education, Employment and Income

<b>D1. Are you currently enrolled in school or a job training program?</b>  <b>[IF ENROLLED]</b> <b>Is it full-time or part-time</b>  <b>[IF CLIENT IS INCARCERATED, CODE D1 AS 'NOT ENROLLED']</b>	<i>Mark appropriate box with an 'X'; please specify if 'other'</i>	
	<input type="checkbox"/>	Not enrolled
	<input type="checkbox"/>	Enrolled, FULL TIME
	<input type="checkbox"/>	Enrolled, PART TIME
	<input type="checkbox"/>	Refused
	<input type="checkbox"/>	Don't Know
	<input type="checkbox"/>	Other
	<input type="checkbox"/>	Specify

<b>D2. What is the highest level of education you have finished, whether or not you received a degree?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	Never attended
	<input type="checkbox"/>	1 <sup>st</sup> grade
	<input type="checkbox"/>	2 <sup>nd</sup> grade
	<input type="checkbox"/>	3 <sup>rd</sup> grade
	<input type="checkbox"/>	4 <sup>th</sup> grade
	<input type="checkbox"/>	5 <sup>th</sup> grade
	<input type="checkbox"/>	6 <sup>th</sup> grade
	<input type="checkbox"/>	7 <sup>th</sup> grade
	<input type="checkbox"/>	8 <sup>th</sup> grade
	<input type="checkbox"/>	9 <sup>th</sup> grade
<input type="checkbox"/>	10 <sup>th</sup> grade	

	<b>11<sup>th</sup> grade</b>
	<b>12<sup>th</sup> grade/High School Diploma/Equivalent</b>
	<b>College or University/1<sup>st</sup> year completed</b>
	<b>College or University/2<sup>nd</sup> year completed</b>
	<b>College or University/3<sup>rd</sup> year completed</b>
	<b>Bachelor's Degree (BA,BS) or Higher</b>
	<b>Voc/Tech Program after high school but no voc/tech diploma</b>
	<b>Voc/Tech Diploma after high school</b>
	<b>Refused</b>
	<b>Don't Know</b>

<b>D2a. Were you enrolled in school in the last 60 days?</b>	<i>Mark appropriate box with an 'X'; please specify if 'other'</i>	
		<b>Not enrolled</b>
		<b>Enrolled, FULL TIME</b>
		<b>Enrolled, PART TIME</b>
		<b>Refused</b>
		<b>Don't Know</b>
		<b>Other</b>
	<b>Specify</b>	

<b>D3. Are you currently employed?</b>  <b>[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED OR HAD A REGULAR JOB BUT WAS OFF WORK]</b>	<i>Mark appropriate box with an 'X'; please specify if 'other'</i>	
	<input type="checkbox"/>	<b>Employed, Full Time (35+ hrs per week, or would have been)</b>
	<input type="checkbox"/>	<b>Employed, Part time</b>
	<input type="checkbox"/>	<b>Unemployed, looking for work</b>
	<input type="checkbox"/>	<b>Unemployed, Disabled</b>
	<input type="checkbox"/>	<b>Unemployed, Volunteer work</b>
	<input type="checkbox"/>	<b>Unemployed, Retired</b>
	<input type="checkbox"/>	<b>Unemployed, not looking for work</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Don't Know</b>
	<input type="checkbox"/>	<b>Other</b>
<input type="checkbox"/>	<b>Specify</b>	

E. Crime and Criminal Justice Status

<b>E1. Have you been arrested in the past 6 months?</b>	<i>Mark the appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>

<b>E2. In the past 6 months, how many times have you been arrested for drug-related offenses?</b>	<i>Record the number reported; or mark 'refused' or 'don't know' with an 'X'</i>				
	<input type="checkbox"/>	<b># of months</b>	<input type="checkbox"/>	<b>Refused</b>	<input type="checkbox"/>

<b>E3. In the past 6 months, how many nights have you spent in jail/prison?</b>	<i>Record the number reported; or mark 'refused' or 'don't know' with an 'X'</i>				
		<b># of nights</b>		<b>Refused</b>	

<b>E4. In the past 6 months, how many times have you committed a crime?</b>	<i>Record the number reported; or mark 'refused' or 'don't know' with an 'X'</i>				
		<b># of times</b>		<b>Refused</b>	

<b>E5. Are you currently awaiting charges, trial, or sentencing?</b>	<i>Mark the appropriate box with an 'X'; please specify if 'other'</i>	
		<b>Yes</b>
		<b>No</b>
		<b>Refused</b>
	<b>Don't Know</b>	

<b>E6. Are you currently on parole or probation?</b>	<i>Mark the appropriate box with an 'X'; please specify if 'other'</i>	
		<b>Yes</b>
		<b>No</b>
		<b>Refused</b>
	<b>Don't Know</b>	

## F. Mental and Physical Health Problems and Treatment/Recovery

<b>F1. How would you rate your overall health right now?</b>	<i>Mark the appropriate box with an 'X'; please specify if 'other'</i>
	<input type="checkbox"/> <b>Excellent</b>
	<input type="checkbox"/> <b>Very good</b>
	<input type="checkbox"/> <b>Good</b>
	<input type="checkbox"/> <b>Fair</b>
	<input type="checkbox"/> <b>Poor</b>
	<input type="checkbox"/> <b>Refused</b>
	<input type="checkbox"/> <b>Don't Know</b>

<b>F2a. During the past 6 months, did you receive INPATIENT treatment?</b>	<i>Mark either 'Yes' or 'No' for each item with an 'X'; if 'yes' report the number of nights received treatment.</i>				
	<b>Inpatient treatment for:</b>	<b>Yes</b>	<b>No</b>	<b>Refused</b>	<b>Don't know</b>
<b>[If F2a is 'YES'] F2a.1. For how many nights?</b>	<b>vii. Physical Complaint</b>				
	<input type="checkbox"/> <b># of nights</b>				
	<b>viii. Mental or emotional difficulties</b>				
	<input type="checkbox"/> <b># of nights</b>				
	<b>ix. Alcohol or substance abuse</b>				
	<input type="checkbox"/> <b># of nights</b>				

<b>F2b. During the past 6 months, did you receive INPATIENT treatment?</b>  <b>[If F2b is 'YES']</b> <b>F2b.1. For how many nights?</b>	<i>Mark either 'Yes' or 'No' for each item with an 'X'; if 'yes' report the number of nights received treatment.</i>				
	<b>Outpatient treatment for:</b>	<b>Yes</b>	<b>No</b>	<b>Refused</b>	<b>Don't know</b>
	<b>i. Physical Complaint</b>				
		<b># of nights</b>			
	<b>ii. Mental or emotional difficulties</b>				
		<b># of nights</b>			
	<b>iii. Alcohol or substance abuse</b>				
		<b># of nights</b>			

<b>F2c. During the past 6 months, did you receive EMERGENCY ROOM treatment?</b>  <b>[If F2c is 'YES']</b> <b>F2c.1. For how many nights?</b>	<i>Mark either 'Yes' or 'No' for each item with an 'X'; if 'yes' report the number of nights received treatment.</i>				
	<b>ER treatment for:</b>	<b>Yes</b>	<b>No</b>	<b>Refused</b>	<b>Don't know</b>
	<b>i. Physical Complaint</b>				
		<b># of nights</b>			
	<b>ii. Mental or emotional difficulties</b>				
		<b># of nights</b>			
	<b>iii. Alcohol or substance abuse</b>				
		<b># of nights</b>			

<b>F4. Have you ever been tested for HIV?</b>	<i>Mark appropriate box with an 'X'</i>	
		<b>Yes</b>
		<b>No</b>
		<b>Refused</b>
	<b>Don't Know</b>	

<b>F4a. Do you know the results of your HIV testing?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>

<b>F7. Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief?)</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>
	<input type="checkbox"/>	<b>Refused</b>
<input type="checkbox"/>	<b>Don't Know</b>	

<b>F7a. Have had nightmares about it or thought about it when you did not want to?</b>	<i>Mark appropriate box with an 'X'; skip if response to question F7 is 'No', 'Refused' or 'Don't know'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>
	<input type="checkbox"/>	<b>Refused</b>
<input type="checkbox"/>	<b>Don't Know</b>	

<b>F7b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?</b>	<i>Mark appropriate box with an 'X'; skip if response to question F7 is 'No', 'Refused' or 'Don't know'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>
	<input type="checkbox"/>	<b>Refused</b>
<input type="checkbox"/>	<b>Don't Know</b>	

<b>F7c. Were constantly on guard, watchful or easily startled?</b>	<i>Mark appropriate box with an 'X'; skip if response to question F7 is 'No', 'Refused' or 'Don't know'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Don't Know</b>

<b>F7d. Felt numb and detached from others, activities, or your surroundings?</b>	<i>Mark appropriate box with an 'X'; skip if response to question F7 is 'No', 'Refused' or 'Don't know'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Don't Know</b>

<b>F8. In the past 6 months, how often have you been hit, kicked, slapped or otherwise physically hurt?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Never</b>
	<input type="checkbox"/>	<b>A few times</b>
	<input type="checkbox"/>	<b>More than a few times</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Don't Know</b>

<b>F8. In the past 6 months, how often have you been hit, kicked, slapped or otherwise physically hurt?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Never</b>
	<input type="checkbox"/>	<b>A few times</b>
	<input type="checkbox"/>	<b>More than a few times</b>
	<input type="checkbox"/>	<b>Refused</b>
<input type="checkbox"/>	<b>Don't Know</b>	

### G. Social Connectedness

<b>G1. In the past 6 months, did you attend any voluntary self-help groups that were not affiliated with a religious or faith-based organization?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>
	<input type="checkbox"/>	<b>Refused</b>
<input type="checkbox"/>	<b>Don't Know</b>	

<b>G1.1. Specify how many times</b>	<i>Record the number reported; or mark 'refused' or 'don't know' with an 'X'; skip if the response to question G1 is 'No', 'Refused', or 'Don't know'</i>				
	<input type="checkbox"/>	<b># of times</b>	<input type="checkbox"/>	<b>Refused</b>	<input type="checkbox"/>

<b>G2. In the past 6 months, did you attend any religious/faith affiliated self-help groups?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>
	<input type="checkbox"/>	<b>Refused</b>
<input type="checkbox"/>	<b>Don't Know</b>	

<b>G2.1. Specify how many times</b>	<i>Record the number reported; or mark 'refused' or 'don't know' with an 'X'; skip if the response to question G1 is 'No', 'Refused', or 'Don't know'</i>					
		<b># of times</b>		<b>Refused</b>		<b>Don't Know</b>

<b>G3. In the past 6 months, did you attend meetings of organizations that support mental health other than the organizations described above?</b>	<i>Mark appropriate box with an 'X'</i>					
		<b>Yes</b>				
		<b>No</b>				
		<b>Refused</b>				
	<b>Don't Know</b>					

<b>G3.1. Specify how many times</b>	<i>Record the number reported; or mark 'refused' or 'don't know' with an 'X'; skip if the response to question G1 is 'No', 'Refused', or 'Don't know'</i>					
		<b># of times</b>		<b>Refused</b>		<b>Don't Know</b>

<b>G4. In the past 6 months, did you have interaction with family and/or friends that are supportive of your mental health?</b>	<i>Mark appropriate box with an 'X'</i>					
		<b>Yes</b>				
		<b>No</b>				
		<b>Refused</b>				
	<b>Don't Know</b>					

<b>G5. To whom do you turn when you are having trouble?</b>  <b>[Choose all that apply]</b>	<i>Mark appropriate box with an 'X'; please specify if 'other'</i>	
	<input type="checkbox"/>	<b>No one</b>
	<input type="checkbox"/>	<b>Clergy member</b>
	<input type="checkbox"/>	<b>Family member</b>
	<input type="checkbox"/>	<b>Friends</b>
	<input type="checkbox"/>	<b>Clinician</b>
	<input type="checkbox"/>	<b>Refused</b>
	<input type="checkbox"/>	<b>Don't know</b>
	<input type="checkbox"/>	<b>Other</b>
	<b>Specify</b>	

<b>G5a. Emergency department visit for psychiatric reasons in the past 6 months?</b>	<i>Mark either 'Yes' or 'No' for each item with an 'X'; if 'yes' report the number of nights received treatment.</i>		
	<b>Yes</b>	<b>No</b>	<b># of nights</b>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

<b>G5b. If available, has there been a suicide attempt in the past 6 months?</b>	<i>Mark appropriate box with an 'X'</i>	
	<input type="checkbox"/>	<b>Yes</b>
	<input type="checkbox"/>	<b>No</b>