



53917

## Brief Adult Outcome Questionnaire

Version 11

This brief questionnaire asks about some of the most commonly reported thoughts, feelings and behaviors among adults seeking behavioral health treatment. Please think about the past two weeks and answer the questions below to the best of your ability. This will help you and your therapist/doctor to plan your treatment and monitor your improvement.

| How often did you...   | Never                 | Hardly ever           | Some-<br>times        | Often                 | Very often            |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <i>Feel unhappy or sad?</i>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Have little or no energy?</i>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Have a hard time getting along with family, friends, or coworkers?</i>      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Feel hopeless about the future?</i>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Have a hard time paying attention?</i>                                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Feel unproductive at work or other daily activities?</i>                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Feel tense or nervous?</i>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Have problems with sleep (too much or too little)?</i>                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Feel lonely?</i>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Think about harming yourself?</i>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Have someone express concerns about your alcohol or drug use?</i>           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Have more than five drinks of alcohol at one time?</i>                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Have a problem at work, school, or home because of alcohol or drug use?</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Please take a moment to access your last session to help us better serve your needs:

| Please answer according to their relevance.                              | True                  | Almost True           | Unsure                | Almost False          | False                 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <i>I felt that we talked about the things that were important to me.</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>I felt that the therapist liked and understood me.</i>                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>I felt that the session was helpful.</i>                              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>I felt confident that the therapist and I worked well together.</i>   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

|                            |   |   |   |          |            |   |   |   |               |   |   |   |   |   |   |   |
|----------------------------|---|---|---|----------|------------|---|---|---|---------------|---|---|---|---|---|---|---|
| <b>For Office Use Only</b> |   |   |   | Site ID: | Session #: |   |   |   |               |   |   |   |   |   |   |   |
| Date Completed:            | □ | □ | / | □        | □          | / | □ | □ | Org ID:       | □ | □ | □ | □ | □ | □ |   |
| Client ID:                 | □ | □ | □ | □        | □          | □ | □ | □ | Clinician ID: | □ | □ | □ | □ | □ | □ | □ |

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For more information on this and other questionnaires visit [www.psychoutcomes.org](http://www.psychoutcomes.org)

Fax completed forms to: 800-961-1224

