From:	Schroeder, Mary E
To:	Rachel Dixon
Subject:	FW: PRO00047663 Decision Letter
Date:	Thursday, February 1, 2024 2:28:57 PM

CAUTION: External

Libby Schroeder, MD FACS
Senior Medical Director-Acute Care Services, Froedert Hospital
Associate Professor of Surgery
Division of Trauma & Acute Care Surgery
Medical College of Wisconsin

From: help-ebridge@mcw.edu [mailto:help-ebridge@mcw.edu]
Sent: Tuesday, January 2, 2024 4:40 PM
To: Timmer-Murillo, Sydney <stimmer@mcw.edu>; Schroeder, Mary E <meschroeder@mcw.edu>
Cc: Hanchek, Emmalee <ejhanchek@mcw.edu>; Kazmierski, Taylor <tkazmierski@mcw.edu>; Griffin, Sara <sgriffin@mcw.edu>; Manriquez Prado, Anakaren <amanriquez@mcw.edu>; Koceja, Chris <ckoceja@mcw.edu>; Diaquino, Vanessa <vdiaquino@mcw.edu>; Herdeman, Caroline <cherdeman@mcw.edu>; Brooks, Scott <sbrooks@mcw.edu>; Brandolino, Amber <abrandolino@mcw.edu>; Jazinski-Chambers, Kelley <kjazinski@mcw.edu>
Subject: PRO00047663 Decision Letter

Medical College of Wisconsin
Institutional Review Board

To: Mary Schroeder, MD
Sydney Timmer-Murillo, PhD
CC: Caroline Herdeman
Amber Brandolino
Kelley Jazinski-Chambers

Date: **1/2/2024**

Re: **Project Title**: A Multi-Center Evaluation of the Impact of Trauma Center Mental Health Screening and Intervention on Patient Outcomes
PRO ID: PRO00047663

The MCW Institutional Review Board #5 has granted an exemption from IRB oversight for the above-referenced submission in accordance with 45 CFR 46.104(d)(2)(4).

The items listed below were submitted and reviewed when the IRB approved this submission. Research must be conducted according to the IRB approved documents listed below:

Other-Phone script
ICF- Informed Consent Form
PRO- Study Protocol
SUR-Six month mental health follow up questions
DCF- Data collection form
SUR- Rand Short Form
SUR- DASS-21
SUR- CESD-R
SUR-PCL 5
SUR- Demographics
SUR-Life Events Checklist

The consent form and related HIPAA authorization is effective as of 01/02/2024. Signed consent forms for each subject must be kept on file as part of the project records.

The IRB also granted approval of a waiver of HIPAA authorization requirements at 45 CFR 164 for the purpose of Records Review for Potential Subjects.

The Principal Investigator is responsible for notifying the IRB via Amendment prior to the initiation of any additions or modifications made to this project. On an annual basis, you will be asked to complete an exempt status update report, so that the IRB can maintain an accurate record of all current projects.

If your project involves the use of any Froedtert Health resource such as, space, staff services, supplies/equipment or any ancillary services - lab, pharmacy, radiology, protected health/billing information or specimen requests, OCRICC approval is required before beginning any research activity at those sites.

Please notify the IRB when all project activities have been completed.

If you have any questions, please contact the IRB Coordinator II for this IRB Committee, Chris Koceja, at 414-955-2603 or ckoceja@mcw.edu.

Sincerely,

Joseph Carroll, PhD
IRB Chair
MCW Institutional Review Board #5

DCF – Chart Review of Injury related services

MRN: ________

Admit date:

Age:

Gender:

Race:

Ethnicity:

Insurance Status

Mechanism of Injury:

Blunt or Penetrating?

Blunt:
□ MVC
□ Auto vs. Peds (Pedestrian)
□ Fall
□ Assault
□ MCC (Motorcycle Collision / Crash)
□ Machinery
□ Other, please specify

Penetrating:
□ GSW (Gunshot wound)
□ Shotgun (Shotgun wound)
□ Stab (Stab Wound)
□ Other

Injuries (check all that apply)
□ Head (including Brain)
□ Face
□ Neck
□ Spine
□ Chest
□ Abdomen
□Pelvis
□Extremity

Injury Severity Score: ________________________________

Hospitalization

Length of Hospital Stay: _________________________

ICU LOS: __________________________________

Discharge Disposition:
□ Home
□ Acute rehab
□ Subacute rehab
□ Skilled nursing facility
□ Longterm Acute Care Hospital
□ Jail
□Inpatient Mental Health Facility
□ Other, if so specify

Inpatient Mental Health Services

Mental Health Screening performed? Yes No

What screening tool was used?
Injured Trauma Survivor Screen (ITSS)
Automated screener
Post-Traumatic Stress Disorder Symptom Measure (eg. PTSD checklist for DSM-5)
Other, if so specify

Was an inpatient mental health intake performed? Yes No

Reason for consult? _____________________________

Number of inpatient encounters? _________________________

Duration of visits? _________________________________

Per chart, self-reported prior psychiatric diagnoses; choose any that apply:
□ Trauma & Stress based disorder (e.g., PTSD, Acute Stress disorder)
□ Depressive disorders (e.g., Major Depressive episode, Persistent depressive disorder)
□ Anxiety-Based disorders (e.g., Generalized Anxiety Disorder, phobia),
□ Psychotic Disorders
□ Substance Use Disorders
□Developmental Disorder (e.g. Attention Deficit Hyperactivity Disorder)
□ Other

Per chart, self-reported prior psychiatric diagnoses; choose any that apply:
□ Trauma & Stress based disorder (e.g., PTSD, Acute Stress disorder)
□ Depressive disorders (e.g., Major Depressive episode, Persistent depressive disorder)
□ Anxiety-Based disorders (e.g., Generalized Anxiety Disorder, phobia),

□ Psychotic Disorders
□ Substance Use Disorders
□Developmental Disorder (e.g. Attention Deficit Hyperactivity Disorder)
□ Other

Interventions provided; Multiple choices, check all that apply
□ Psychoeducation
□ Emotional validation/support
□ Behavioral intervention (e.g, breathing exercise, progressive muscle relaxation, relaxation strategies)
□ Cognitive behavioral intervention (e.g., identifying maladaptive cognitions, reframing thoughts)
□ Health behavior intervention (e.g., pain management strategies, engagement in therapies/cares)
□ Motivational interviewing
□ Family/social support intervention
□ Treatment planning
□ Resource connection (e.g., child life, violence intervention, social work, AODA)
□ Other, is so specify

Mental health follow-up recommended?
□ Yes
□ No
□ Other, please specify:

<u>Post-discharge services</u>

Number of outpatient mental health follow ups: ____________________

Mental health diagnoses:
□ Trauma & Stress based disorder (e.g., PTSD, Acute Stress disorder)
□ Depressive disorders (e.g., Major Depressive episode, Persistent depressive disorder)
□ Anxiety-Based disorders (e.g., Generalized Anxiety Disorder, phobia),
□ Psychotic Disorders
□ Substance Use Disorders
□Developmental Disorder (e.g. Attention Deficit Hyperactivity Disorder)
□ Other

<u>Injury-related outcomes</u>
Number of outpatient visits for injury-related care: ____________________________

Number of ED visits: _________________________________

Number of readmissions: _______________________________

Eastern Association for the Surgery of Trauma
Advancing Science, Fostering Relationships, and Building Careers

EAST MULTICENTER STUDY
DATA DICTIONARY

Mental Health Screening and Referral Study – Data Dictionary

Data Entry Points and appropriate definitions / clarifications:

Entry space	Definition / Instructions
Standard Study Questions	
Admit Date	Admission date of the patient enrolled
Age	Age of patient at time of injury
Gender	Gender of Patient enrolled: choice best option
	Male
	Female
	Non-binary
	Other
Race	Single choice for best description of racial background of patient enrolled. Options include:
	American Indian or Alaska Native
	Asian
	Native Hawaiian or Other pacific Islander
	Black or African American
	White
	A race not listed. Please specifiy:
	Prefer not to say
Ethnicity	Single choice for best description of ethnic background of patient enrolled.
	Hispanic
	Non-Hispanic
Insurance	Choose best option:
	Private/commercial
	Medicare
	Medicaid
	Workmen's Compensation
	Uninsured/self pay
	Other
Mechanism of initial Injury	

Blunt	Single choice for best description of blunt mechanism (if penetrating mechanism proceed to next data point) Options include:
	MVC
	Auto vs. Peds (Pedestrian)
	Fall
	Assault
	MCC (Motorcycle Collision / Crash)
	Machinery Other, please specify
Penetrating	Single choice for best description of penetrating mechanism. Options include:
	GSW (Gunshot wound)
	Shotgun (Shotgun wound)
	Stab (Stab Wound)
	Other
Injuries	Multiple choices, check any that apply
	Head (including Brain)
	Face
	Neck
	Spine
	Chest
	Abdomen
	Pelvis
	Extremity
ISS (Injury Severity Score)	Numerical value for calculated ISS
Hospitalization	
Length of Hospital Stay	Free text entry of number of consecutive days patient was admitted to the hospital. Should be determined by number of midnights spent in hospital
ICU LOS (days)	Free text entry of number of consecutive days patient required ICU admission. Should be determined by number of midnights spent in the ICU (ICU = Intensive Care Unit, LOS = Length of Stay)
Discharge Disposition	Single choice for best description:
	Home
	Acute rehab
	Subacute rehab
	Skilled nursing facility
	Longterm Acute Care Hospital
	Jail
	Inpatient Mental Health Facility
	Other, if so specify
Inpatient Mental Health Services	

Mental Health Screening performed	Inpatient screening performed for mental health risk as recommended for Level 1 and 2 trauma centers by the Committee on Trauma, choose appropriate option
	Yes
	No
Screening Tool	Single choice for best description
	Injured Trauma Survivor Screen (ITSS)
	Automated screener
	Post-Traumatic Stress Disorder Symptom Measure (eg. PTSD checklist for DSM-5)
	Other, if so specify
Inpatient Mental Health Intake	Documentation in a consult note of an Initial assessment of a trauma patient for mental health risk, choose appropriate option
	Yes
	No
Reason for consult	Free text as documented in the mental health consult note, what is the reason for the referral
Number of inpatient encounters	Free text indicating cumulative number of notes from mental health practioner
Duration of visits	Free text of cumulative number of minutes spent with patient as indicated in the notes (e.g., Visit length: 30 minutes)
Prior psychiatric diagnoses (as listed in EMR problem list)	Any psychiatric diagnoses listed in past medical history of EMR; multiple choice, check all that apply
	Trauma & Stress based disorder (e.g., PTSD, Acute Stress disorder)
	Depressive disorders (e.g., Major Depressive episode, Persistent depressive disorder)
	Anxiety-Based disorders (e.g., Generalized Anxiety Disorder, phobia),
	Psychotic Disorders
	Substance Use Disorders
	Developmental Disorder (e.g. Attention Deficit Hyperactivity Disorder)
	Other
Per chart, self-reported prior psychiatric diagnoses	Multiple choices, check any that apply
	Trauma & Stress based disorder (e.g., PTSD, Acute Stress disorder)
	Depressive disorders (e.g., Major Depressive episode, Persistent depressive disorder)
	Anxiety-Based disorders (e.g., Generalized Anxiety Disorder, phobia),
	Psychotic Disorders
	Substance Use Disorders
	Developmental Disorder (e.g. Attention Deficit Hyperactivity Disorder)
	Other
Interventions provided:	Per mental health notes, what interventions were provided during the inpatient stay. Multiple choices, check all that apply
	Psychoeducation
	Emotional validation/support

Commented [SME1]: Sydney, add other screeners

	Behavioral intervention (e.g, breathing exercise, progressive muscle relaxation, relaxation strategies)
	Cognitive behavioral intervention (e.g., identifying maladaptive cognitions, reframing thoughts)
	Health behavior intervention (e.g., pain management strategies, engagement in therapies/cares)
	Motivational interviewing
	Family/social support intervention
	Treatment planning
	Resource connection (e.g., child life, violence intervention, social work, AODA)
	Other, is so specify
Mental health follow-up recommended	Was ongoing mental health care recommended for after discharge
	Single choice, options include:
	Yes
	No
	Other, please specify:
Post-Discharge Services:	
Number of outpatient mental health follow ups	Free text, number of outpatient psych notes in 6 months after discharge
Mental health diagnosis	Mental health diagnosis in outpatient notes
	Multiple choices, check any that apply
	Trauma & Stress based disorder (e.g., PTSD, Acute Stress disorder)
	Depressive disorders (e.g., Major Depressive episode, Persistent depressive disorder)
	Anxiety-Based disorders (e.g., Generalized Anxiety Disorder, phobia),
	Psychotic Disorders
	Substance Use Disorders
	Developmental Disorder (e.g. Attention Deficit Hyperactivity Disorder)
	Other
Injury related outcomes	
Number of outpatient visits for injury-related care	Free text, number of injury related office visits that are not mental health related (eg trauma clinic, orthopedics, pain management) in 6 months post-discharge
Number of ED visits	Free text, number of ED visits in 6 months post-discharge
Number of readmissions	Free text, number of readmissions related to injury? in 6 months post-discharge

6 Month Survey

Patient number:
Name:
MRN:

1. Did you receive treatment for your mental health since your injury?

    □ None,
    □ Psychiatry (e.g., medication management),
    □ Psychotherapy (e.g, counseling, Trauma-focused therapy),
    □ Both psychiatry and psychotherapy,
    □ Other, please specify: ______________________________________

    If yes, who referred you?
    □ Trauma surgeon/APP
    □ Primary care doctor
    □ Other, please specify: ____

2. Where did you/are you receiving treatment?

    □ within health system that treated my injury
    □ within a different health system
    □ at a community location

    If yes, how many sessions have you completed? ____________________

    If yes, how soon after injury did you begin treatment?
    □ within 1 month
    □ 1-2 months
    □ n3-4 months
    □ 4 months or later

3. Are you still undergoing treatment? □ yes □ no

Rand Short Form Health Survey – SF-12

For each of the following questions, please mark an ☒ in the one box that best describes your answer.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities?
If so, how much?

a. Moderate activities, such as moving a table, pushing a vacuum cleaning, bowling or playing golf…

Yes, limited a lot	Yes, limited a little	No, not limited at all
☐	☐	☐

b. Climbing several flights of stairs...

Yes, limited a lot	Yes, limited a little	No, not limited at all
☐	☐	☐

3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

a. Accomplished less than you would like…

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

b. Were limited in the kind of work or other activities…

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

4. During the past 4 weeks, how much of the time have you had any of the following probkems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

a. Accomplished less than you would like…

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

b. Did work or other activities less carefully than usual…

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

6. These questions are about how you feel and how things have been with you <u>during the past 4 weeks.</u> For each question, please give the one answer that comes closest to the way you have been feelings. How much of the time during the <u>past 4 weeks</u>…

a. Have you felt calm and peaceful?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

b. Did you have a lot of energy?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

c. Have you felt downhearted and depressed?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

7. During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Please answer these questions as they relate to the **last 6 months**, since the time of your initial survey.

Event	*Happened to me*	*Witnessed it*	*Learned about it*	*Not Sure*	*Doesn't apply*
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

PCL-5

<u>Instructions</u>: **Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem <u>in the past month</u>.**

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Center for Epidemiologic Studies Depression Scale – Revised (CESD-R)

Below is a list of the ways you might have felt or behaved. Please check the boxes to tell me how often you have felt this way in the past week or so.	Last Week				Nearly every day for 2 weeks
	Not at all *or* Less than 1 day	1 - 2 days	3 - 4 days	5 - 7 days	
My appetite was poor.	0	1	2	3	4
I could not shake off the blues.	0	1	2	3	4
I had trouble keeping my mind on what I was doing.	0	1	2	3	4
I felt depressed.	0	1	2	3	4
My sleep was restless.	0	1	2	3	4
I felt sad.	0	1	2	3	4
I could not get going.	0	1	2	3	4
Nothing made me happy.	0	1	2	3	4
I felt like a bad person.	0	1	2	3	4
I lost interest in my usual activities.	0	1	2	3	4
I slept much more than usual.	0	1	2	3	4
I felt like I was moving too slowly.	0	1	2	3	4
I felt fidgety.	0	1	2	3	4
I wished I were dead.	0	1	2	3	4
I wanted to hurt myself.	0	1	2	3	4
I was tired all the time.	0	1	2	3	4
I did not like myself.	0	1	2	3	4
I lost a lot of weight without trying to.	0	1	2	3	4
I had a lot of trouble getting to sleep.	0	1	2	3	4
I could not focus on the important things.	0	1	2	3	4

REFERENCE: Eaton, W. W., Smith, C., Ybarra, M., Muntaner, C., Tien, A. (2004). Center for Epidemiologic Studies Depression Scale: review and revision (CESD and CESD-R). In ME Maruish (Ed.). *The Use of Psychological Testing for Treatment Planning and Outcomes Assessment* (3rd Ed.), Volume 3: Instruments for Adults, pp. 363-377. Mahwah, NJ: Lawrence Erlbaum.

DASS21

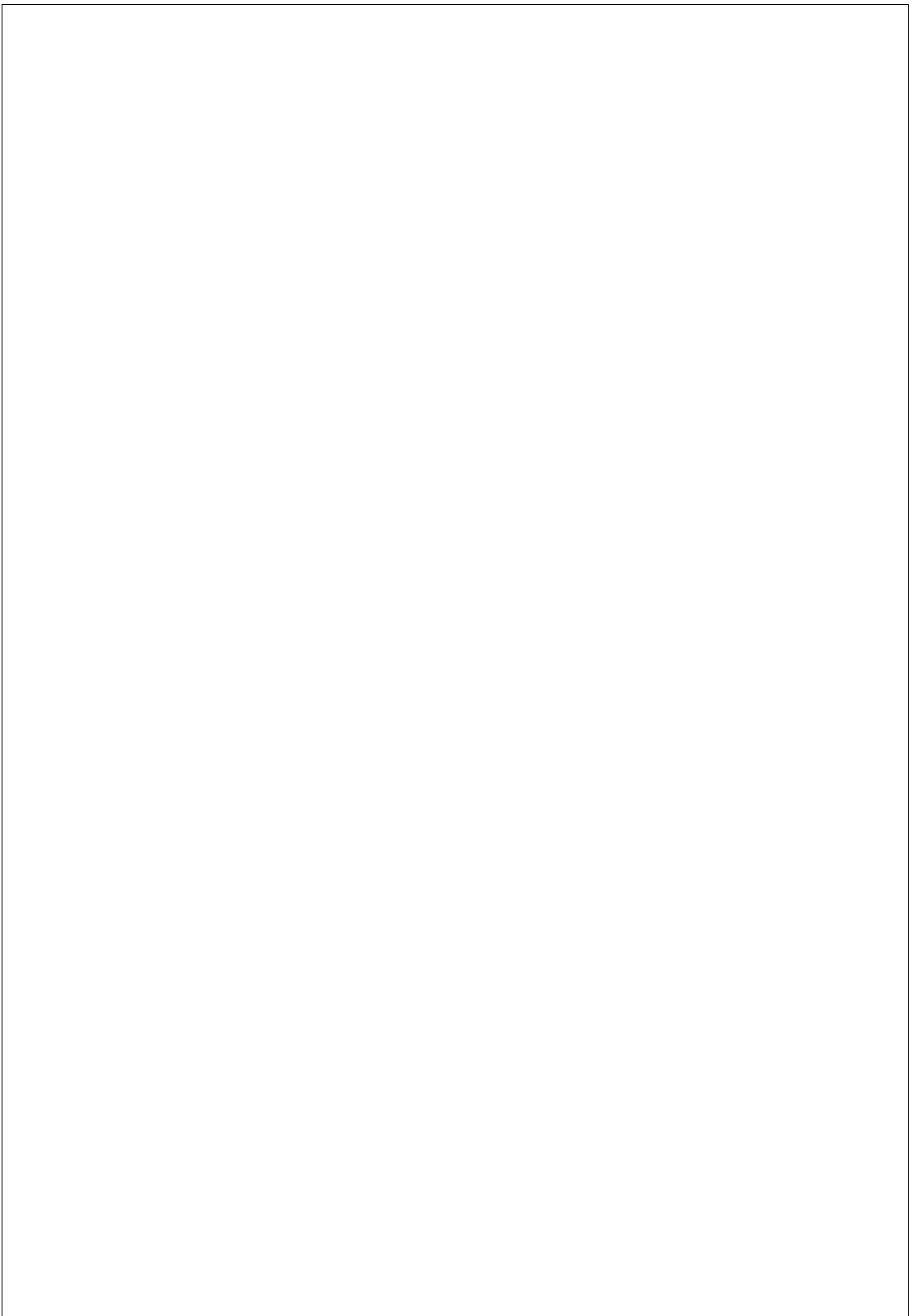
Name: Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree or a good part of time
3 Applied to me very much or most of the time

1 (s)	I found it hard to wind down	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g. in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt down-hearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	I felt I wasn't worth much as a person	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3



Initial Survey

Patient number:
Name:
MRN:

Basics from patient

1. Date of interview/data collection: ______________________________
2. Do you have a history of a formal psychiatric dx or tx (i.e. anxiety, depression, other)?

   □ No □ Yes; list diagnosis: ______________________________________

   If yes, type of treatment: □ Meds □ Psychotherapy □ No Treatment

   Meds: (list type and dose): __________________________________
3. Do you have a current diagnosis of chronic pain: □ Yes □ No
4. Do you have a previous diagnosis of chronic pain: □ Yes □ No
5. Currently, what is your activity level?
   - □ bedridden,
   - □ able to get around with help,
   - □ able to get around independently
6. Do you have a history of sleep and rest disturbance: □ Yes □ No

   If yes, do you have difficulty: □ Falling asleep □ Staying asleep □ Both
7. Do you have a sleep disorder diagnosis? □ Yes □ No

   If yes, please list: _______________________________
8. Do you use nicotine products:
   - □ Everyday
   - □ Some days
   - □ Former user
   - □ Never
   - □ Unknown
9. Do you currently take prescription medications? □ Yes □ No

   If yes, please provide name(s), dosage and how often you take them: ____________________
10. Do you currently take over the counter OTC medications of a regular basis? □ Yes □ No

    If yes, please provide name(s), dosage and how often you take them: ____________________
11. Do you currently use street drugs? □ Yes □ No

    If yes, which drugs: ____

    How often :
    - □ Everyday
    - □ Some days
    - □ Occasionally
12. Please select the responses that best fits you or you may select the box indicating you do not wish to provide this information. (These definitions are what is currently used by the National Institute of Health)

    A. Do you consider yourself to be Hispanic or Latino? (See definition below.) Select one.

1. ***Hispanic or Latino***. A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."
2. ***Not Hispanic or Latino***
3. Check here if you do not wish to provide this information.

B. What race do you consider yourself to be? Select one or more of the following.

1. ***American Indian or Alaska Native***. A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliation or community attachment.
2. ***Asian***. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
3. ***Native Hawaiian or Other Pacific Islander***. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
4. ***Black or African American***. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" can be used in addition to "Black" or African American."
5. ***White***. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
6. A race not listed. Please specify:
7. I prefer not to say.

Gender Identity (GI)

13. What sex were you assigned at birth, on your original birth certificate?
    1. Male
    2. Female
    3. I prefer not to answer

14. What is your current gender identity? (Check all that apply)
    1. Male
    2. Female
    3. Trans male/trans man
    4. Trans female/trans woman
    5. Nonbinary/gender fluid/gender expansive
    6. Two-spirit
    7. Genderqueer/gender non-conforming
    8. Different identity (please state): ________
    9. I prefer not to answer

Family & Relationships (FR)

15. Relationship Status:
    1. Married
    2. Other committed relationship (or relationships)

3. Divorced
4. Separated
5. Widowed
6. Single
7. I prefer not to answer

Socioeconomic Position (SEP)

16. What is the highest grade or level of school you have completed or the highest degree you have received?

    □ NEVER ATTENDED/KINDERGARTEN ONLY;
    □ Elementary School
    □ Junior High School
    □ High School
    □ GED or equivalent
    □ Some college, no degree
    □ Associates Degree
    □ Bachelor's Degree (Example: BA, BS)
    □ Master's degree (EXAMPLE: MA, MS, MEng, MEd, MBA);
    □ Professional degree (EXAMPLE: MD, DDS, DVM, JD);
    □ Doctoral degree (EXAMPLE: PhD, EdD);
    □ Refused
    □ Don't know

17. What is your current working situation?

    □ Working for wages or salary with an employer (full- or part-time)
    □ Working for wages, but currently on sick leave for more than 3 months
    □ Self-employed or own-account worker
    □Working as an unpaid family member (e.g., working in a family business
    □ Retired because of health condition
    □Retired due to age
    □Early retirement
    □ Not working

18. If not working, what is the main reason you are not currently working?

    □ Health condition or disability
    □ Still engaged in training
    □ Personal family responsibilities
    □ Could not find suitable work
    □ Do not know how or where to seek work
    □ Do not have the economic need
    □ Parents or spouse did not let me work
    □ I prefer not to answer
    □ A reason not listed. Please state: ___________________

19. What is your best estimate of the total income of ALL family members from all sources, before taxes, in the last calendar year

    □ $0 - $10,000
    □ $10,000 – $20,000

□ $20,000 - $30,000
□ $30,000 - $40,000
□ $40,000 - $50,000
□ $50,000 - $60,000
□ $60,000 - $70,000
□ $70,000 - $80,000
□ $80,000 - $90,000
□ $90,000 - $100,000
□ Greater than $100,000
□ I prefer not to answer

20. What best describes your current living situation?

□ Rent apartment
□ Rent room(s) within another person's home
□ Own home
□ Homeless or living in a shelter
□ Doubled up with another family
□ Live with parents/other family
□ A living situation not listed. Please describe: ______________________

21. Do you have insurance?

□ Yes
□ No

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it _happened to you_ personally, (b) you _witnessed it_ happen to someone else, (c) you _learned about it_ happening to someone close to you, (d) you're _not sure_ if it fits, or (e) it _doesn't apply_ to you.

Be sure to consider your _entire life_ (growing up as well as adulthood) as you go through the list of events.

Event	*Happened to me*	*Witnessed it*	*Learned about it*	*Not Sure*	*Doesn't apply*
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

PCL-5

<u>Instructions</u>: **Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem <u>in the past month</u>.**

In the past month, how much were you bothered by:	***Not at all***	***A little bit***	***Moderately***	***Quite a bit***	***Extremely***
1. Repeated, disturbing, and unwanted memories of the stressful experience?	**0**	**1**	**2**	**3**	**4**
2. Repeated, disturbing dreams of the stressful experience?	**0**	**1**	**2**	**3**	**4**
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	**0**	**1**	**2**	**3**	**4**
4. Feeling very upset when something reminded you of the stressful experience?	**0**	**1**	**2**	**3**	**4**
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	**0**	**1**	**2**	**3**	**4**
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	**0**	**1**	**2**	**3**	**4**
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	**0**	**1**	**2**	**3**	**4**
8. Trouble remembering important parts of the stressful experience?	**0**	**1**	**2**	**3**	**4**
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	**0**	**1**	**2**	**3**	**4**
10. Blaming yourself or someone else for the stressful experience or what happened after it?	**0**	**1**	**2**	**3**	**4**
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	**0**	**1**	**2**	**3**	**4**
12. Loss of interest in activities that you used to enjoy?	**0**	**1**	**2**	**3**	**4**
13. Feeling distant or cut off from other people?	**0**	**1**	**2**	**3**	**4**
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	**0**	**1**	**2**	**3**	**4**
15. Irritable behavior, angry outbursts, or acting aggressively?	**0**	**1**	**2**	**3**	**4**
16. Taking too many risks or doing things that could cause you harm?	**0**	**1**	**2**	**3**	**4**
17. Being "superalert" or watchful or on guard?	**0**	**1**	**2**	**3**	**4**
18. Feeling jumpy or easily startled?	**0**	**1**	**2**	**3**	**4**
19. Having difficulty concentrating?	**0**	**1**	**2**	**3**	**4**
20. Trouble falling or staying asleep?	**0**	**1**	**2**	**3**	**4**