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# HCHS/SOL Well-Being Questionnaire

ID NUMBER:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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FORM CODE: WBE  
VERSION: A  
5/17/07

Contact Occasion	<input type="text"/>	<input type="text"/>	SEQ #	<input type="text"/>	<input type="text"/>
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Acrostic: \_\_\_\_\_

## ADMINISTRATIVE INFORMATION

0a. Completion Date:  /  /

0b. Staff ID:

**Instructions:** Mark the appropriate box for the response. Unless instructed, mark **ONLY** one response.

### A. CES-D 10

*Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the **past week**. (Mark only one on each line)*

	Rarely or none of the time (<1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. I had trouble keeping my mind on what I was doing.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. I felt depressed.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. I felt that everything I did was an effort.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. I felt hopeful about the future.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. I felt fearful.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. My sleep was restless.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. I was happy.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. I felt lonely.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
10. I could not "get going".	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

ID NUMBER:							
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Contact  
Occasion

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SEQ #

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### B. Spielberger Trait Anxiety Scale

Choose the appropriate response for each statement that indicates how you generally feel. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

	Almost never	Sometimes	Often	Almost always
11. I feel nervous and restless.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
12. I feel satisfied with myself.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
13. I wish I could be as happy as others seem to be.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
14. I feel like a failure.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
15. I worry too much over something that really doesn't matter.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
16. I lack self-confidence.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
17. I feel secure.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
18. I feel inadequate.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
19. I am a steady person.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
20. I get in a state of tension or turmoil as I think over my recent concerns and interests.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>