

Site ID:

Service Provider:

Date:

Service User:

IMPORTANT - PLEASE READ THIS FIRST

This form has 10 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes

OVER THE LAST WEEK	Not at all	Only Occasionally	Sometimes	Often	Most or all of the time	OFFICE USE ONLY	
						CORE 10	CORE 10R
1. I have felt tense, anxious or nervous.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	<input type="checkbox"/>
2. I have felt I have someone to turn to for support when needed.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>	<input type="checkbox"/>
3. I have felt able to cope when things go wrong.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/>	<input type="checkbox"/>
4. Talking to people has felt too much for me.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	<input type="checkbox"/>
5. I have felt panic or terror.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	<input type="checkbox"/>
6. I made plans to end my life.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	<input type="checkbox"/>
7. I have had difficulty getting to sleep or staying asleep.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	<input type="checkbox"/>
8. I have felt despairing or hopeless.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	<input type="checkbox"/>
9. I have felt unhappy.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	<input type="checkbox"/>
10. Unwanted images or memories have been distressing me.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>	<input type="checkbox"/>

CORE 10 **CORE 10R**
TOTAL SCORES *

*** PROCEDURE:**

Quick method for the CORE-10 (if all items completed): Add together the item scores to get the Clinical Score.
For the CORE-10R : Insert the score from question 6

(if all items NOT completed): Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score.

Thank you for your time in completing this questionnaire