Name:_____ MR:_____ Date:____/____/_____

Utrecht Gender Dysphoria Scale (Male to Female)

Instructions: Below are a series of statements that you may agree or disagree with. Please be as open and honest as possible in your responding as to how you feel about each statement and mark your selection with an X.

	Completely Agree	Somewhat Agree	Neutral	Somewhat Disagree	Completely Disagree
1) My life would be meaningless if I would have to live as a boy (man).					
2) Every time someone treats me like a boy (man) I feel hurt.					
3) I feel unhappy if someone calls me a boy (man).					
4) I feel unhappy because I have a male body.					
The idea that I will always be a boy (man) gives me a sinking feeling.					
6) I hate myself because I'm a boy (man).					
7) I feel uncomfortable behaving like a boy (man) always and everywhere.					
8) Only as a girl (woman) my life would be worth living.					
9) I dislike urinating in a standing position.					
10) I am dissatisfied with my beard growth because it makes me look like a boy (man).					
11) I dislike having erections.					
12) It would be better not to live than to live as a boy (man).					

Total Score:_____

Therapist:_____ Therapist Signature:_____

Name:_____ MR:_____ Date:____/____/_____

The Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (Male to Female Version)

Instructions: Below are a series of questions about your feelings for the past 12 months. Please be as open and honest as possible in your responding as to how frequent each question happens to you and mark your selection with an X.

In the last 12 months…	Always (1)	Often (2)	Sometimes (3)	Rarely (4)	Never (5)
1) Have you felt satisfied being a man?					
2) Have you felt uncertain about your gender, that is, feeling somewhere in between a man and a woman?					
3) Have you felt pressured by others to be a man, although you don't really feel like one?					
4) Have you felt, unlike most men, that you have to work at being a man?					
5) Have you felt that you were not a real man?					
6) Have you felt, given who you really are (e.g. What you like to do, how you act with other people), that it would be better for you to live as a woman rather than as a man?					
7) Have you had dreams in which you were a woman?					
8) Have you felt unhappy about being a man?					
9) Have you felt uncertain about yourself, at times feeling more like a woman and at times feeling more like a man?					
10) Have you felt more like a woman than like a man?					
11) Have you felt that you did not have anything in common with either women or men?					
12) Have you been bothered by seeing yourself identified as male or having to check the box "M" for male on official forms (e.g., employment applications, driver's license, pastport)?					
13) Have you felt comfortable when using men's restrooms in public places?					
14) Have strangers treated you as a woman?					
15) At home, have people you know, such as friends and relatives, treated you as a woman?					
16) Have you had the wish or desire to be a woman?					
17) At home, have you dressed and acted as a woman?					
18) At parties or other social gatherings, have you presented yourself as a woman?					

19) At work or at school, have you presented yourself as a woman?					
20) Have you disliked your body because it is male? (e.g. having a penis or having hair on your chest, arms and legs)?					
21) Have you wished to have hormone treatment to change your body into a woman's?					
22) Have you wished to have an operation to change your body into a woman's (e.g., to have your penis removed or to have a vagina made)?					
23) Have you made an effort to change your legal sex (e.g., on a driver's license or credit card?					
24) Have you thought of yourself as a "hermaphrodite" or an "intersex" rather than as a man or a woman?					
25) Have you thought of yourself as a "transgender person"?					
26) Have you thought of yourself as a woman?					
27) Have you thought of yourself as a man?					

Total Score:_____

Therapist:_____ Therapist Signature:_____

Scoring: All items are coded 1 to 5, except Items 1, 13 & 27 are reversed scored from 5 to 1. The total score is obtained by the sum score of the completed items divided by the number of marked items. The lower the score the higher the degree of Gender Dysphoria.

Name:_____ Date:___/___/____ MR:_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Therapist:_____ Therapist Signature:_____

Name:_____ MR:_____ Date:____/____/____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Severity Range:

___ 0-4: Minimum

___ 5-9: Mild

___ 10-14: Moderate

___ 15-21: Severe

Therapist:_____ Therapist Signature:_____

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screener/Recent – Self-Report

Name:_____ MR:_____ Date:___/___/____

Answer Questions 1 and 2	In The Past Month: YES	In The Past Month: NO
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts about killing yourself?***		
If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6		
3) ***Have you thought about how you might do this?***		
4) ***Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?***		
5) ***Have you started to work out or worked out the details of how to kill yourself?*** ***Do you intend to carry out this plan?***		
	In the Past 3 Months	
6) ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
In your entire lifetime, how many times have you done any of these things?		

Therapist Name:_____ Therapist Signature:_____

Name:_____ MR:_____ Date:___/___/____

Alcohol Use Disorders Identification Test – AUDIT

Please select the answer that is most correct for you to each of the following questions.

1) How often do you have a drink containing alcohol? *(If you answer never, jump to questions 9&10)*

(0) Never (1) Monthly or less (2) 2-4 times a month (3) 2-3 times per week (4) 4 or more times a week

2) How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1-2 (1) 3-4 (2) 5-6 (3) 7-8 (4) 10 or more

3) How often do you have six or more drinks on one occasion?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4) How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5) How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

6) How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7) How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8) How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9) Have you or someone else been injured as a result of your drinking?

(0) No (2) Yes, but not in the last year (3) Yes, during the last year

10) Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?

(0) No (2) Yes, but not in the last year (3) Yes, during the last year

Total Score:_____

Therapist:_____ Therapist Signature:_____

MR:_____

Patient's Name:	Date:

Drug Abuse Screening Test—DAST-10

These Questions Refer to the Past 12 Months

1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Total Score:_____

Guidelines for Interpretation of DAST-10

Interpretation (Each "Yes" response = 1)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4):363-371.
Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007;32:189-198.

Therapist:_____ Therapist Signature:_____

Name:_____ MR:_____ Date:____/____/_____

Rosenberg's Self-Esteem Scale (Rosenberg, 1965)

Instructions: Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. I feel that I'm a person of worth, at least on an equal plane with others.				
2. I feel that I have a number of good qualities.				
3. All in all, I am inclined to feel that I am a failure.				
4. I am able to do things as well as most other people.				
5. I feel I do not have much to be proud of.				
6. I take a positive attitude toward myself.				
7. On the whole, I am satisfied with myself.				
8. I wish I could have more respect for myself.				
9. I certainly feel useless at times.				
10. At times I think I am no good at all.				

Total Score:_____

Scoring: To score the items, assign a value to each of the 10 items as follows:

- **For items 1, 2, 4, 6, 7:** Strongly Agree=3, Agree=2, Disagree=1, and Strongly Disagree=0.
- **For items 3, 5, 8, 9, 10** (which are reversed in valence, and noted with the asterisks** below): Strongly Agree=0, Agree=1, Disagree=2, and Strongly Disagree=3.

The scale ranges from 0-30, with 30 indicating the highest score possible. Higher scores indicate higher self-esteem. Scores below 15 indicate low self-esteem.

Therapist:_____ Therapist Signature:_____

Name:_____ MR:_____ Date:____/____/_____

Satisfaction With Life Scale (SWLS)

Instructions: Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

7 - Strongly agree

6 - Agree

5 - Slightly agree

4 - Neither agree nor disagree

3 - Slightly disagree

2 - Disagree

1 - Strongly disagree

____ In most ways my life is close to my ideal.

____ The conditions of my life are excellent.

____ I am satisfied with my life.

____ So far I have gotten the important things I want in life.

____ If I could live my life over, I would change almost nothing.

Total Score: _____

Severity Range:

31 – 35: Extremely satisfied

26 – 30: Satisfied

21 – 25: Slightly satisfied

20: Neutral

15 – 19: Slightly dissatisfied

10 – 14: Dissatisfied

5 - 9: Extremely dissatisfied

Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin as noted in the 1985 article in the *Journal of Personality Assessment.*

Therapist:_____ Therapist Signature:_____