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| **Core Symptom Index** |
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| **In the past 1 week** How often did you feel disturbed by the following symptoms?Please use X on the number you agree with the most. | Not at all | little | somewhat | Quite much | most |
|  |  |  |  |  |  |
| 1. A ringing or Buzzing in the ear(s)
 | 0 | 1 | 2 | 3 | 4 |
| 1. Suicidal idea
 | 0 | 1 | 2 | 3 | 4 |
| 1. Tremor
 | 0 | 1 | 2 | 3 | 4 |
| 1. Crying
 | 0 | 1 | 2 | 3 | 4 |
| 1. Self-blaming
 | 0 | 1 | 2 | 3 | 4 |
| 1. Feeling lonely
 | 0 | 1 | 2 | 3 | 4 |
| 1. Depressed
 | 0 | 1 | 2 | 3 | 4 |
| 1. Trouble catching breath
 | 0 | 1 | 2 | 3 | 4 |
| 1. Hot or cold spells
 | 0 | 1 | 2 | 3 | 4 |
| 1. Feeling numb or tingling
 | 0 | 1 | 2 | 3 | 4 |
| 1. A fullness in head or nose
 | 0 | 1 | 2 | 3 | 4 |
| 1. Discomfort when in a crowd
 | 0 | 1 | 2 | 3 | 4 |
| 1. Upset when being left alone
 | 0 | 1 | 2 | 3 | 4 |
| 1. Feeling agitated
 | 0 | 1 | 2 | 3 | 4 |
| 1. feeling urge to do things
 | 0 | 1 | 2 | 3 | 4 |
|   |  |  |  |  |  |