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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 | |
|  |  |  |  | |  |  | |