All questions contained in this questionnaire are strictly confidential. Thank you for your complete answers.

Please reflect on your sense of well-being, taking into account your physical, mental, emotional, social and spiritual condition over the past month.
Rate your well-being by writing in a number 1-100: (100 = complete well-being)

Name (Last, First, M.I.): Can be replaced with a code if anonymous is preferred	☐ M ☐ F	DOB:
Genetic Background	☐ African ☐ Ashkenazi ☐ Asian ☐ European ☐ Native American ☐ Latino ☐ Middle Eastern ☐ Mediterranean ☐ ___	
Marital status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Number of children	Ages of Children:	
Who lives in your household?		
Highest Education	☐ High School ☐ Some college ☐ Undergraduate Degree ☐Graduate/Professional Degree	
Occupation	**Job title**	

HEALTH HABITS AND LIFESTYLE

Alcohol, Tobacco, & Substance Use	Do you drink alcohol?	☐ Yes ☐ No	How many drinks per week?	
	Are you concerned about the amount you drink?	☐ Yes ☐ No	Have you every experienced black outs?	☐ Yes ☐ No
	Have you considered stopping?	☐ Yes ☐ No	Are you prone to "binge" drinking?	☐ Yes ☐ No
	Do you use tobacco (what form)?	☐ Yes ☐ No	If yes, amount per day?	Number of years?
	Have you smoked more than 10 cigarettes (or used chewing tobacco) ever in your life?	☐ Yes ☐ No	If yes, number of years?	Year quit:
	Are you currently using any recreational drugs?	☐ Yes ☐ No	Have you ever used IV or inhaled recreational drugs?	☐ Yes ☐ No
Lifestyle	Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Cola/Soda ☐ DIET Cola/Soda ☐ Cocoa/Chocolate # of cups/cans/servings per day?			
	How many of the last SEVEN DAYS have you followed a healthful eating plan? (circle one)	If yes, specify:		
	On how many of the last SEVEN DAYS did you eat beans, legumes, and/or WHOLE grains?	If yes, specify:		
	On how many of the last SEVEN DAYS did you eat five or more servings of fruits and vegetables?			
	On how many of the last SEVEN DAYS did you eat nuts, seeds, fish or non-fried seafood?	0 1 2 3 4 5 6 7		
	On how many of the last SEVEN DAYS did you **avoid** high fat animal foods such as red meat or full fat dairy?	0 1 2 3 4 5 6 7		
	In a typical week, how many times do you do the following kinds of exercise for more than 15 minutes:	0 1 2 3 4 5 6 7		
	☐ Sedentary (No exercise)	0 1 2 3 4 5 6 7		
	☐ Mild Exercise (climb stairs, walk 3 blocks, yoga, stretching, pilates, golf)	0 1 2 3 4 5 6 7		
	☐ Moderate Exercise (fast walking, tennis, dancing, surfing, level 2-3 yoga, weight training)			
	☐ Vigorous Exercise (running, jogging, soccer, long distance bicycling)			

PSYCHOSOCIAL HISTORY

STRESS					
Rate the impact of stress in these areas of your life. Please write in your rating of 1-10, 10 being most stress)					
Work	Family	Social	Finances	Health	Other?

DAILY SPIRITUAL INVOLVEMENT					
Do you have a spiritual practice? If so, what?					
	Many times a day	*Everyday*	*Most days*	*Once in awhile*	*Never or almost never*
1. I feel a higher spiritual presence	☐	☐	☐	☐	☐
2. I find strength and comfort in my religion or spirituality	☐	☐	☐	☐	☐
3. I feel deep inner peace and harmony	☐	☐	☐	☐	☐
4. I feel the love of a greater spirit for me directly or through others	☐	☐	☐	☐	☐
5. I am spiritually touched by the beauty of creation	☐	☐	☐	☐	☐
6. I desire to be closer to God or in union with the divine	☐	☐	☐	☐	☐

DEPRESSION SCREENING (PHQ-8)				
Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep or sleeping too much				
4. Feeling tired or having too little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things such as reading, the newspaper, or watching television				
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				

QUALITY OF LIFE (SF-12)					
1. In general, would you say your health is?	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
2. Does your health now limit you in these activities during a typical day? If so, how much?					
2a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	☐ Yes, a lot limited	☐ Yes, a little limited	☐ No, not limited at all		
2b. Climbing several flights of stairs?	☐ Yes, a lot limited	☐ Yes, a little limited	☐ No, not limited at all		
3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?					
3a. Accomplished less then you would like?	☐ All of the time	☐ Most of the time	☐ Some of the time	☐ A little of the time	☐ None of the time
3b. Were limited in the kind of work or other activities?	☐ All of the time	☐ Most of the time	☐ Some of the time	☐ A little of the time	☐ None of the time
4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?					
4a. Accomplished less then you would like?	☐ All of the time	☐ Most of the time	☐ Some of the time	☐ A little of the time	☐ None of the time
4b. Were limited in the kind of work or other activities?	☐ All of the time	☐ Most of the time	☐ Some of the time	☐ A little of the time	☐ None of the time
5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?	☐ Not at all	☐ A little bit	☐ Moderately	☐ Quite a bit	☐Extremely
6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks:					
6a. Have you felt calm and peaceful?	☐ All of the time	☐ Most of the time	☐ Some of the time	☐ A little of the time	☐ None of the time

6b. Did you have a lot of energy?	☐ All of the time	☐ Most of the time	☐ Some of the time	☐ A little of the time	☐ None of the time
6c. Have you felt downhearted and depressed?	☐ All of the time	☐ Most of the time	☐ Some of the time	☐ A little of the time	☐ None of the time
7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	☐ All of the time	☐ Most of the time	☐ Some of the time	☐ A little of the time	☐ None of the time

POSITIVE AND NEGATIVE AFFECT

This scale consists of a number of words that describe different feelings and emotions. Read each item and then list the number from the scale below next to each word. Indicate to what extent you feel this way right now, that is, at the present moment OR indicate the extent you have felt this way over the past week (circle the instructions you followed when taking this measure)

1 ***Very slightly or Not at all***	***2*** ***A little***	***3*** ***Moderately***	***4*** ***Quite a bit***	***5*** ***Extremely***

	1. Interested		11. Irritable
	2. Distressed		12. Alert
	3. Excited		13. Ashamed
	4. Upset		14. Inspired
	5. Strong		15. Nervous
	6. Guilty		16. Determined
	7. Scared		17. Attentive
	8. Hostile		18. Jittery
	9. Enthusiastic		19. Active
	10. Proud		20. Afraid

SOCIAL SUPPORT (Duke-UNC)

*Here is a list of things that other people do for us or give us that may be helpful or supportive. Read each statement and pick the response that is **closest** to your situation. There are no right or wrong answers.*	*As much as I would like*	*Almost as much as I would like*	*Some of how much I would like*	*Not quite as much as I would like*	*A little less than I would like*	*Much less than I would like*
1. There are people who care what happens to me	☐	☐	☐	☐	☐	☐
2. I get love and affection						
3. I have someone to talk to about problems at work or with my housework						
4. I have someone to talk to about my personal and family problems						
5. I get chances to talk about money matters						
6. I get invitations to go out and do things with other people						
7. I can get help when I'm sick in bed						
8. I can get useful advice about important things in life						

PTSD Checklist - Military Version (PCL-M)

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful military experience?					
2.	Repeated, disturbing *dreams* of a stressful military experience?					
3.	Suddenly *acting* or *feeling* as if a stressful military experience were *happening again* (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful military experience?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful military experience?					
6.	Avoid *thinking about* or *talking about* a stressful military experience or avoid *having feelings* related to it?					
7.	Avoid *activities* or *talking about* a stressful military experience or avoid *having feelings* related to it?					
8.	Trouble *remembering important parts* of a stressful military experience?					
9.	Loss of *interest* in things that you used to enjoy?					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short?*					
13.	Trouble *falling* or *staying* asleep?					
14.	Feeling *irritable* or having *angry outbursts?*					
15.	Having *difficulty* concentrating?					
16.	Being "*super alert*" or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

Has anyone indicated that you've changed since the stressful military experience? Yes __ No__

Body Perception Questionnaire Body Awareness Very Short Form
Stephen W. Porges © 1993, 2015

Image how aware you are of your body processes. Select the answer that most accurately describes you. Please rate your awareness on each of the characteristics described below.

During most situations I am aware of:

		Never	Occasionally	Sometimes	Usually	Always
1	My mouth being dry	o	o	o	o	o
2	How fast I am breathing	o	o	o	o	o
3	A swelling of my body or parts of my body	o	o	o	o	o
4	Muscle tension in my arms and legs	o	o	o	o	o
5	A bloated feeling because of water retention	o	o	o	o	o
6	Goose bumps	o	o	o	o	o
		Never	Occasionally	Sometimes	Usually	Always
7	Stomach and gut pains	o	o	o	o	o
8	Stomach distension or bloatedness	o	o	o	o	o
9	Tremor in my lips	o	o	o	o	o
10	The hair on the back of my neck "standing up"	o	o	o	o	o
11	An urge to swallow	o	o	o	o	o
12	How hard my heart is beating	o	o	o	o	o
		Never	Occasionally	Sometimes	Usually	Always