THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

BASIS-24® (Behavior And Symptom Identification Scale)

1☐ Admission/Intake
2☐ Mid-treatment
3☐ Discharge termination
4☐ Post-treatment follow-up

Instructions to Respondents:

This survey asks about how you are feeling and doing in different areas of life. Please check the box to the left of your answer that best describes yourself during the ***PAST WEEK***. Please answer every question. If you are unsure about how to answer, please give the best answer you can.

EXAMPLE: *During the past week,* how much difficulty did you have sleeping?

0☐ No difficulty
1☐ A little difficulty
2☑ Moderate difficulty
3☐ Quite a bit of difficulty
4☐ Extreme difficulty

During the PAST WEEK, how much difficulty did you have …

1. **Managing your day-to-day life:**
   0☐ No difficulty
   1☐ A little difficulty
   2☐ Moderate difficulty
   3☐ Quite a bit of difficulty
   4☐ Extreme difficulty

2. **Coping with problems in your life?**
   0☐ No difficulty
   1☐ A little difficulty
   2☐ Moderate difficulty
   3☐ Quite a bit of difficulty
   4☐ Extreme difficulty

3. **Concentrating:**
   0☐ No difficulty
   1☐ A little difficulty
   2☐ Moderate difficulty
   3☐ Quite a bit of difficulty
   4☐ Extreme difficulty

During the *PAST WEEK, how much of the time did you …*

4. **Get along with people in your family?**
   0☐ None of the time
   1☐ A little of the time
   2☐ Half of the time
   3☐ Most of the time
   4☐ All of the time

5. **Get along with people outside your family?**
   0☐ None of the time
   1☐ A little of the time
   2☐ Half of the time
   3☐ Most of the time
   4☐ All of the time

6. **Get along well in social situations:**
   0☐ None of the time
   1☐ A little of the time
   2☐ Half of the time
   3☐ Most of the time
   4☐ All of the time

During the PAST WEEK, how much of the time did you…

7. **Feel close to another person?**
   0☐ None of the time
   1☐ A little of the time
   2☐ Half of the time
   3☐ Most of the time
   4☐ All of the time

8. **Feel like you had someone to turn to if you needed help?**
   0☐ None of the time
   1☐A little of the time
   2☐ Half of the time
   3☐ Most of the time
   4☐ All of the time

9. **Feel confident in yourself:**

Name: Medical Record #: DOB:

0☐ None of the time
1☐ A little of the time
2☐ Half of the time
3☐ Most of the time
4☐ All of the time

During the PAST WEEK, how much of the time did you …

10. Feel sad or depressed?

0☐ None of the time
1☐ A little of the time
2☐ Half of the time
3☐ Most of the time
4☐ All of the time

11. Think about ending your life?

0☐ None of the time
1☐ A little of the time
2☐ Half of the time
3☐ Most of the time
4☐ All of the time

12. Feel nervous?

0☐ None of the time
1☐ A little of the time
2☐ Half of the time
3☐ Most of the time
4☐ All of the time

During the PAST WEEK, how often did you …

13. Have thoughts racing through your head?

0☐ Never
1☐ Rarely
2☐ Sometimes
3☐ Often
4☐ Always

14. Think you had special powers?

0☐ Never
1☐ Rarely
2☐ Sometimes
3☐ Often
4☐ Always

15. Hear voices or see things?

0☐ Never
1☐ Rarely
2☐ Sometimes
3☐Often
4☐ Always

16. Think people were watching you?

0☐ Never
1☐ Rarely
2☐ Sometimes
3☐ Often
4☐ Always

17. Think people were against you?

0☐ Never
1☐ Rarely
2☐ Sometimes
3☐ Often
4☐ Always

During the PAST WEEK, how often did you…

18. Have mood swings?

0☐ Never
1☐ Rarely
2☐ Sometimes
3☐ Often
4☐ Always

19. Feel short-tempered?

0☐ Never
1☐ Rarely
2☐ Sometimes
3☐ Often
4☐ Always

20. Think about hurting yourself?

0☐ Never
1☐ Rarely
2☐ Sometimes
3☐ Often
4☐ Always

During the PAST WEEK, how often…

21. Did you have an urge to drink alcohol or take street drugs?

0☐ Never
1☐ Rarely
2☐ Sometimes
3☐ Often
4☐ Always

22. Did anyone talk to you about your drinking or drug use?

0☐ Never
1☐ Rarely
2☐ Sometimes
3☐ Often
4☐ Always

23. Did you try to hide your drinking or drug use?

0☐ Never

1☐ Rarely
2☐ Sometimes
3☐ Often
4☐ Always

24. Did you have problems from your drinking or drug use?

0☐ Never
1☐ Rarely
2☐ Sometimes
3☐ Often
4☐ Always

ABOUT YOU

25. How old are you? _____

26. What is your sex?

1☐ Male
2☐ Female

27. Are you…

1☐ Hispanic or Latino
2☐ NOT Hispanic or Latino

28. What is your racial background?

1☐ American Indian or Alaskan native
1☐ Asian
3☐ Black or African-American
4☐ White/Caucasian
5☐ Native Hawaiian or other Pacific Islander
6☐ Multiracial or other (specify)

29. How much school have you completed?

1☐ 8th grade or less
2☐ Some high school
3☐ High school graduate/GED
4☐ Some college
5☐ 4-year college graduate or higher

30. Are now you …

1☐ Married
2☐ Separated
3☐ Divorced
4☐ Widowed
5☐ Never married

31. Outside of your treatment providers, what is your main source of social support?

1☐ Wife, husband or partner
2☐ Other family (parents, children, relatives)
3☐ Friends/roommates
4☐ Community/church
5☐ Other
6☐ No one

32. Where did you sleep in the past 30 days?

1☐ Apartment or house
2☐ Halfway house/group home/board and care home/residential center/ supervised housing
3☐ School or dormitory
4☐ Hospital or detox center
5☐ Nursing home/assisted living
6☐ Shelter/street
7☐ Jail/prison
8☐ Other (fill in) _____

33. At any time in the past 30 days, did you work at a paying job?

1☐ No
2☐ Yes, 1-10 hours per week
3☐ Yes, 11-30 hours per week
4☐ Yes, more than 30 hours per wee

34. **At any time in the past 30 days, did you work at a volunteer job?**

1☐ No
2☐ Yes, 1-10 hours per week
3☐ Yes, 11-30 hours per week
3☐ Yes, more than 30 hours per week

35. At any time in the past 30 days, were you a student in a high school, job training, or college degree program?

1☐ Yes
2☐ No

36. **Do you now receive disability benefits; for example, SSI, SSDI, or other disability insurance (Check one or more)**

    1☐ No
    2☐ Yes, I receive disability for medical reasons
    3☐Yes, I receive disability for psychiatric reasons
    4☐ Yes, I receive disability for substance abuse

37. **Today's Date: __ __/__ __/__ __**

THANK YOU VERY MUCH!