# Form Submission

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| Date Completed | 04/11/2021 |
| Submission Reference | B80967FA793273294F0312EA172A7895 |
| Form1 Reference | PCMIS: LS000319 |

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|---|
| Are you completing this for yourself or on behalf of someone else? |
| For myself |
| What is your ethnic group |
| White |
| Which one best describes your White background? |
| British, English, Northern Irish, Scottish, or Welsh |
| Sexual orientation - Which of the following options best describes you? |
| Straight or heterosexual |
| Are you a carer for a family member or friend? |
| Yes |
| Who do you care for? |
| Test |
| What sort of things do they need your help with? |
| Test |
| Would you like us to send you information about support for carers? |
| Yes |
| Have you ever been a member of the British Armed forces |
| Yes |
| When did you leave the British Armed Forces (approximately)? |
| Test |
| Are you a parent? Or do you have parental responsibility for anyone? |
| No |
| Are you or your partner pregnant? |
| No |
| Do you have a long-term physical health condition? |
| Yes |
| Which long-term physical health condition(s) do you have? |
| ["Diabetes","Heart disease"] |
| Other (please specify) |
| |
| How often do you have a drink containing alcohol? |

| |
|---|
| Monthly or less |
| How many drinks do you have on a typical day when you are drinking? |
| 3 or 4 |
| How often do you have six or more drinks on one occasion? |
| Monthly |
| Do you take any recreational/street drugs or non-prescription drugs? |
| Yes |
| Please tell us which street/recreational or non-prescription drugs you take? |
| Test |
| Do you smoke cigarettes or use tobacco? |
| Yes |
| Would you like support to quit or cut down smoking or using tobacco? |
| Yes |
| What are you looking for help with? |
| Test |
| How long has this been a problem for you? |
| 1-3 months |
| Are you having any treatment for anxiety, low mood, depression or any other mental health difficulties? |
| ["I am prescribed medication"] |
| It would be really helpful if you could describe your current treatment in as much detail as possible e.g. name of medication if you know it, type of talking treatment you are having. |
| Test |
| In the past have you had any treatment for anxiety, low mood, stress or other mental health difficulties |
| ["I was supported by a team (e.g. crisis team or recovery team)"] |
| It would be really helpful if you could describe your past treatment in as much detail as you feel able e.g. name of medication if you know it, type of talking treatment. |
| Test |
| Are you concerned about any of the following |
| ["Housing","Debt","Benefits","Immigration status","My physical activity levels"] |
| Please provide more information about your housing concerns |
| Test |
| Please provide more information about your debt concerns |

Test

Please provide more information about your benefit concerns

Test

Please provide more information about your imigration concerns

Test

Please provide more information about your physical activity level concerns

Test

Would you like us to provide you with information about organisations that could offer you support on any of the below?

["Housing","Debt","Benefits","Immigration status","My physical activity levels"]

Over the last 2 weeks, how often have you been bothered by any of the following problems?

| | |
|---|---|
| Feeling nervous, anxious or on edge? | Not at all |
| Not being able to stop or control worrying? | Several days |
| Worrying too much about different things? | More than half the days |
| Trouble relaxing? | Nearly every day |
| Being so restless that it is hard to sit still? | More than half the days |
| Becoming easily annoyed or irritable? | Several days |
| Feeling afraid as if something awful might happen? | Not at all |

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

| | |
|---|---|
| Please tick if you are retired or choose not to have a job for reasons unrelated to your problem | 0 |
| Home Management - Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc. | 1 |
| Social Leisure Activities - with other people e.g. parties, pubs, outings, entertaining etc. | 2 |
| Private Leisure Activities - Done alone e.g. reading, gardening, sewing, hobbies, walking etc. | 3 |
| Family and Relationships - form and maintain close relationships with others including the people that I live with | 4 |

Over the last 2 weeks, how often have you been bothered by any of the following problems?

| | |
|---|---|
| Little interest or pleasure in doing things? | Not at all |
| Feeling down, depressed, or hopeless? | Several days |
| Trouble falling or staying asleep, or sleeping too much? | More than half the days |
| Feeling tired or having little energy? | Nearly every day |
| Poor appetite or overeating? | More than half the days |
| Feeling bad about yourself - or that you are a failure or have let yourself or your family down? | Several days |
| Trouble concentrating on things, such as reading the newspaper or watching television? | Not at all |
| 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? | Several days |
| Thoughts that you would be better off dead, or of hurting yourself in some way? | More than half the days |

Have you had thoughts about harming yourself or ending your life in the past?

Yes

Do you have any current plans to end your life?

Yes

Do you feel able to keep yourself safe?

Yes

Have you done anything to harm yourself?

Yes

Would you like to continue to the section on different types of anxiety?

Yes, I would like to answer questions about different types of anxiety

Have you recently had a panic attack, where you suddenly felt frightened, anxious or extremely uncomfortable?

Yes

When you last had a panic attack how long did the feelings last?

fsfs

How often do you experience intense anxiety or panic attacks?

fds

Are the panic attacks very distressing and do they significantly interfere with your day to day life?

fdsf

Are you afraid of going out of the house alone, being in crowds, standing in queues, or travelling on buses, tubes or trains?

Yes

How often do you experience these feelings?

Test

Do you avoid some situations because of your feelings of anxiety?

Yes

Do you need to have someone with you to go into certain situations?

| |
|---|
| No |
| Fear of embarrassment causes me to avoid doing things or speaking to people. |
| A little bit |
| I avoid activities in which I am the centre of attention? |
| Somewhat |
| Being embarrassed or looking stupid are among my worst fears. |
| Not at all |
| Are there certain things you are very afraid of, like flying , heights, seeing blood, enclosed spaces, or certain animals or insects? |
| Yes |
| 78 What is the situation or animal that causes you to feel afraid? |
| Test |
| Does this cause you significant distress or have a big impact on your life? |
| Test |
| What are you most afraid of happening? |
| Test |
| Are you bothered by repeating thoughts or actions that you feel you must do? |
| Yes |
| Do you fear that something bad will happen if you don’t get rid of thoughts or do something? |
| Test |
| How much time do the thoughts or actions take up each day? |
| 15 minutes |
| Over the last 6 months have you found it difficult to stop worrying? |
| Yes |
| What things do you usually worry about? |
| Test |
| Do you worry about things that might happen in the future or things that happened in the past? |
| Both of the above |
| Does the worrying interfere with you life e.g. stop you doing something you want to do? |

Test

Has anything extremely upsetting or traumatic ever happened to you?

Yes

Do you have flashbacks, thoughts or nightmares about the event?

["Flashbacks","Thoughts"]

Do you try hard not to think about it or go out of your way to avoid reminders?

Test

Do you feel constantly on guard or easily startled?

Test

Do you worry a lot about being unwell with an illness that the doctors haven't found?

Yes

How much of the time are you worried about your health?

Test

Have you been to the doctor to have any tests?

Test

Does worry about your health cause you a lot of distress or stop you doing things you would like to do?

Test

Can we add your contact details to our research database?

Yes

What interests do you have or what activities do you enjoy doing?

Test

How have you coped with difficult feelings in the past?

Test

Are there people in your life who provide you support?

Test