



Baseline Questionnaire

Instructions:

Complete with participant during 1st PEARLS Session. Note results in PEARLS Tracking Chart.

Participant's name:	Today's date:
Address:	Phone:
	Zip:
Case Manager's name:	DOB:

1. Ask the participant: ***“Over the last two weeks, how often have you been bothered by any of the following?”*** (Record the following in the appropriate place in each row, depending on their answer: “0” if “not at all”; “1” if “several days”, “2” if “more than half the days”; and “3” if “nearly every day.” Add column sub-totals, then add all points for a total score.

	Not at all	Several days	More than half the days	Nearly every day	
SCORE	0	1	2	3	
1. Little interest or pleasure in doing things.					
2. Feeling down, sad, or hopeless.					
3. Trouble falling asleep, staying asleep, or sleeping too much.					
4. Feeling tired or having 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.					
9. Thoughts that you would be better off dead or of hurting yourself in some way.					
Add columns					
					TOTAL

Scoring Information:

Minor depression = Two to four symptoms with a score of 2 or 3 (shaded areas), with *at least one* of the symptoms being a cardinal (“hallmark”) symptom (Question 1 or 2)

Major depression = Five or more symptoms with a score of 2 or 3 (shaded areas), with *at least one* of the symptoms being a cardinal (“hallmark”) symptom (Question 1 or 2)

2. Ask the participant the following questions and check the answer provided.

Psychological Treatment	Yes	No	Don't Know	N/A
2. Are you being treated, or have you ever been treated for depression or other emotional problems?		(If no, go to 3)		
2a. If yes, when and for how long?	(Year) (Duration)			
2b. Who is/was treating you?	(Name)			
2c. What diagnosis, if any, were you given?				
2d. Have you ever been on any prescription anti-depressant or anti-anxiety medications?		(If no, go to 3)		
2e. Are you currently taking anti-depressant or anti-anxiety medications? Medication name/mg/# tablets/frequency/route: _____	(If yes, specify)			
2f. Have you previously had any other type of treatment for depression? _____	(If yes, specify)			

3. In general, how would you describe your health? (Circle one answer.)

- a) excellent b) very good c) good d) fair e) poor

4. Social activities are those that involve contact with other people, such as going to faith communities, clubs or associations, or visiting friends or family members. During the ***past month***, which statement describes how socially active you have been? (Circle one answer.)











- a) none b) a little c) fairly active d) quite active e) very active f) extremely active

5. During the *past month*, what type of **social activity/activities** have you been involved in? (Note the average number of times per week you do the listed activity.)

Activity	Average times per week
a) in-person visit with friends or family (other than those you live with)	
b) telephone contacts with friends/family	
c) visit to senior center or community center	
d) volunteer work	
e) attendance at church, club or association	
f) other (specify)	

6. **Physical activities** are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work or transportation. The following questions ask about the amount and intensity of physical activity you usually do. The intensity of the activity is related to the amount of energy you use to do these activities.

Examples of physical activity intensity levels:

<p>Light activities</p> <ul style="list-style-type: none"> • your heart beats slightly faster than normal • you can talk and sing 	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Walking Leisurely</p> </div> <div style="text-align: center;">  <p>Stretching</p> </div> <div style="text-align: center;">  <p>Vacuuming or Light Yard Work</p> </div> </div>
<p>Moderate activities</p> <ul style="list-style-type: none"> • your heart beats faster than normal • you can talk but not sing 	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Fast Walking</p> </div> <div style="text-align: center;">  <p>Aerobics Class</p> </div> <div style="text-align: center;">  <p>Strength Training</p> </div> <div style="text-align: center;">  <p>Swimming Gently</p> </div> </div>
<p>Vigorous activities</p> <ul style="list-style-type: none"> • your heart rate increases a lot • you can't talk or your talking is broken up by large breaths 	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Stair Machine</p> </div> <div style="text-align: center;">  <p>Jogging or Running</p> </div> <div style="text-align: center;">  <p>Tennis, Racquetball, Pickleball or Badminton</p> </div> </div>

How physically active are you? (Check one answer on each line)

Does this accurately describe you?

R A P A 1	1	I rarely or never do any physical activities.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	2	I do some light or moderate physical activities, but not every week.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	3	I do some light physical activity every week.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	4	I do moderate physical activities every week, but less than 30 minutes a day or 5 days a week.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	5	I do vigorous physical activities every week, but less than 20 minutes a day or 3 days a week.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	6	I do 30 minutes or more a day of moderate physical activities, 5 or more days a week.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	7	I do 20 minutes or more a day of vigorous physical activities, 3 or more days a week.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
R A P A 2	3 = Both 1 & 2	1	I do activities to increase muscle strength , such as lifting weights or calisthenics, once a week or more.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		2	I do activities to improve flexibility , such as stretching or yoga, once a week or more.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Coding Instructions:

RAPA 1: Aerobic

To code, choose the question with the highest score with an affirmative response. Any number less than 5 is sub-optimal.

For coding or summarizing categorically:

Sedentary = I rarely or never do any physical activities. (Code a 1)

Under-active =

- I do some light or moderate physical activities, but not every week. (Code a 2)
- I do some light physical activity every week.(Code a 3)

Under-active regular =

- I do moderate physical activities every week, but less than 30 minutes a day or 5 days a week. (Code a 4)
- I do vigorous physical activities every week, but less than 20 minutes a day or 3 days a week. (Code a 4)

Active =

- I do 30 minutes or more a day of moderate physical activities, 5 or more days a week. (Code a 6)
- I do 20 minutes or more a day of vigorous physical activities, 3 or more days a week. (Code a 7)

RAPA 2: Strength & Flexibility

Code a 0 if the participant answers No to both RAPA 2 (Strength or Flexibility) questions.

Code a 1 if the participant answers Yes to the following Strength question:

- I do activities to increase muscle strength, such as lifting weights or calisthenics, once a week or more.

Code a 2 if the participant answers Yes to the following Flexibility question:

- I do activities to improve flexibility, such as stretching or yoga, once a week or more.

Code a 3 if the participant answers Yes to both RAPA 2 (Strength or Flexibility) questions.

7. **Pleasant activities** are those that you enjoy. Some may be also considered social activities, like visiting with friends, while others may also be physical activities, like gardening. The main point is that the activity gives you pleasure and that it is something you can initiate on your own. During the *past month*, how often have you participated in pleasant activities? (Circle one answer. Refer to Pleasant Activity List if client needs a prompt.)

- a) every day b) nearly every day c) half the month d) less than half the month e) hardly at all



Problem List

Participant Name: _____

Counselor Name: _____

Start Date: _____

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____



PHQ-9: PEARLS Sessions

Client's name:	Today's date:
Address:	Phone:
	Zip:
Case Manager's name:	DOB:

1. Ask the client: ***“Over the last two weeks, how often have you been bothered by any of the following?”*** (Record the following in the appropriate place in each row, depending on their answer: “0” if “not at all”; “1” if “several days”, “2” if “more than half the days”; and “3” if “nearly every day.” Add column sub-totals, then add all points for a total score.

	Not at all	Several days	More than half the days	Nearly every day	
SCORE	0	1	2	3	
1. Little interest or pleasure in doing things.					
2. Feeling down, sad, or hopeless.					
3. Trouble falling asleep, staying asleep, or sleeping too much.					
4. Feeling tired or having 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.					
9. Thoughts that you would be better off dead or of hurting yourself in some way.					
Add columns					TOTAL

Minor depression = Two to four symptoms with a score of 2 or 3 (shaded areas), with *at least one* of the symptoms being a cardinal (“hallmark”) symptom (Question 1 or 2)

Major depression = Five or more symptoms with a score of 2 or 3 (shaded areas), with *at least one* of the symptoms being a cardinal (“hallmark”) symptom (Question 1 or 2)



PEARLS Worksheet

Progress Review from Last Session:

(use additional sheet if needed)

Participant Name:
Date:
Visit #:

1. Problem:

2. Goal:

3. Possible solutions:	4. Solution Evaluation	
	<i>Advantages</i>	<i>Disadvantages</i>
a.	a.	a.
b.	b.	b.
c.	c.	c.
d.	d.	d.

5. Solution Choice:

6. Steps to Achieve Solution:

I. _____

II. _____

III. _____

IV. _____

V. _____

VI. _____

Activity Planning

Pleasant:

Physical:

Social:



Counselor Self-Assessment of Adherence to PEARLS Procedure

PEARLS Counselor Name: _____ Organization: _____

Participant name: _____ Session #: _____ Date of Session: ___/___/___

Date of Self-assessment (ideally, it should be the same date as the session): ___/___/___

INSTRUCTIONS: This self-assessment tool is for you, to help you to improve your skill. For each item, assess yourself on a scale of 0 to 5, and record the rating on the line next to the item number. For each sub-item, you may also choose to rate your skill at this session in order to help determine your overall score in that area. Be candid -- for all items, focus on your skill, taking into account how difficult the client seemed to be and the stage of therapy.

0	1	2	3	4	5
Very Poor	Poor	Borderline	Satisfactory	Good	Very Good

How well did I help the participant in ...

- _____ 1. **Defining the Problem**
 - _____ Specific, feasible problem chosen
 - _____ Described in objective terms
 - _____ Problem explored, clarified
 - _____ Complex problem broken down
- _____ 2. **Establishing a Realistic Goal**
 - _____ Goal is clearly stated
 - _____ Goal is achievable
 - _____ Goal is set by patient
 - _____ Complex problem broken down into short, mid, and/or long-range goals
- _____ 3. **Generating Solutions**
 - _____ Brainstorming facilitated
 - _____ Solutions from patient
 - _____ Withholding judgment
- _____ 4. **Implementing Decision-Making Guidelines**
 - _____ Consider "Pros" and "Cons" for each solution
 - _____ Resources addressed
 - _____ Potential negative impact addressed (self/others)
- _____ 5. **Choosing the Solution(s)**
 - _____ Deliberate, systematic process
 - _____ Solution(s) satisfies the goals
 - _____ Negative impact is limited

- ___ 6. **Implementing the Preferred Solution(s)**
 - ___ Specific tasks identified
 - ___ Tasks are relevant to solution
 - ___ Realistic behavior required

- ___ 7. **Evaluating the Outcome**
 - ___ Review of all tasks
 - ___ Praise success
 - ___ Exploration of failure
 - ___ Link success to improve mood

- ___ 8. **Activity Planning**
 - ___ Encouraged identification of pleasant activity, physical and/or social activity
 - ___ Reviewed progress of previous week for activities

How well did I do in my...

- ___ 9. **Pacing and Use of Time**
 - ___ Structured session: Beginning, middle, and end
 - ___ Kept within time
 - ___ Tactful limiting of peripheral and unproductive discussion

- ___ 10. **Communication**
 - ___ Facilitated communication (Supportive vocalizations)
 - ___ Provided information jargon-free
 - ___ Used patient's own language and phrases
 - ___ Listened to patient and responding to patient's comments

- ___ 11. **Interpersonal Effectiveness**
 - ___ Warm
 - ___ Confident
 - ___ Professional

- ___ 12. **Global Rating:** How would you rate your PST skill overall in this season?
(Does not need to approach a mathematical average of previous eleven items)

*** Please note comments or questions about this session to discuss at peer consultation:**


PEARLS Tracking Chart

Participant's Name: _____ Phone : _____ Age: _____ Gender: F M Counselor's Name : _____ Primary Healthcare Provider Name : _____ Primary Healthcare Provider phone #: _____	Chronic Conditions: _____ _____ Medication Information (name, dose, start date, adherence): _____ _____ MMSE Score: _____ OR Brief 6-item Memory Cognition Screen Score: _____
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PHQ-9 responses: Not at all = 0; Several days = 1; More than half the days =2; Nearly every day = 3

	Telephone Screen (if applicable)	Baseline	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7	Session 8
Date										
(Write PHQ-Score on each item below)										
1. Lost interest/pleasure										
2. Down/blue/hopeless										
3. Sleep disturbance										
4. Tired/loss energy										
5. Appetite/wt. change										
6. Feeling bad about self										
7. Trouble concentrating										
8. Fidgety or moving slowly										
9. Thoughts of death/suicide										
TOTAL PHQ-9 Score										
Additional Notes: Problem addressed this session										
Current Stressors										
Other symptoms: pain, panic, anxiety, drinking alcohol, perceptual experiences										



Final Questionnaire

Participant name:	Today's date:
Address:	Phone:
	Zip:
Case Manager's name:	DOB:

1. Over the *last two weeks*, how often have you been bothered by any of the following? (Record the following depending on the answer choice: a "0" if "not at all"; "1" if "several days", "2" if "more than half the days"; and "3" if "nearly every day.

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2. In general, how would you describe your health? (Circle one answer.)

- a) excellent b) very good c) good d) fair e) poor

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4. During the *past month*, what type of social activity/activities have you been involved in? (Note the average number of times per week you do the listed activity.)

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a) every day

b) nearly every
day

c) half the
month

d) less than
half the
month

e) hardly at all



Satisfaction Survey

Instructions:

To help us to continuously improve the PEARLS Program, please answer the following questions candidly. Your PEARLS Counselor will not see your individual answers. Thank you for taking time to fill out the Final Questionnaire and this Satisfaction Survey and for your honest answers. When you are done with this survey, please place it with the Final Questionnaire in the addressed, stamped envelope provided by your counselor.

1. Did the PEARLS counseling sessions provide you with useful tools or strategies to use in your every day life? (Please circle your answer)

Yes

No

2. On a scale of 1 – 10, how much do you feel that you benefited from your participation in PEARLS? (Please circle the number)

1	2	3	4	5	6	7	8	9	10
No				Some					Very
Benefit				Benefit					Beneficial

3. If you did benefit from the PEARLS sessions, please describe why. If you did not benefit, please describe why not. (Use a separate sheet if you need more space.)

4. Did you look forward to the sessions? Why or why not?

5. Do you have any additional comments you would like to share regarding your experience with the PEARLS Program?
