Side 1

Health Distress Index Diary

Form HDID-45

Name or I.D. :_____ **Date of Day 1:**_____

Rate Degree of Experience Items #1 to #40): 4 = Very High 3 = High 2 = Moderate 1 = Low __ = None

	Symptoms or Experiences	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
1.	Difficulty falling asleep at night							
2.	Difficulty remaining asleep at night							
3.	Felt sleep duration was inadequate or insufficient							
4.	Felt tired, drowsy, or fatigued during the day							
5.	Felt full of energy and vitality during the day							
6.	Felt good, happy, elated							
7.	Took time to engage in fun or enjoyable activities							
8.	Socialized with people you like to be with							
9.	Felt confident or optimistic about things							
10.	Able to work productively and accomplish tasks							
11.	Back pain							
12.	Headaches							
13.	Shoulder tension or stiff neck							
14.	Aches or stiffness in hands, feet, arms, or legs							
15.	Chest pain or tightness or tenderness in breasts							
16.	Abdominal pain or discomfort							
17.	Nausea or vomiting							
18.	Constipation, diarrhea, or flatulence (gas)							
19.	Coughing or difficulty breathing							
20.	Felt ill, feverish, sick, or malaise							
21.	Sore throat, runny nose, or swollen lymph glands							
22.	Felt dizzy, weak, or faint							
23.	Undereating or low appetite							
24.	Cold or numb feelings in hands or feet							
25.	Pounding or rapid heart beats or heart palpitations							
26.	Sweating not due to exercise or external heat							
27.	Trembling, jittery, or shaking							
28.	Felt tense, agitated, frustrated, or restless							
29.	Nervous, anxious, or scared							
30.	Worried about finances or work/school pressures							
31.	Fear of losing control or being overwhelmed							
32.	Difficulty concentrating or making decisions							
33.	Excessive overeating or binge eating							
34.	Felt inadequate, worthless, or low self-esteem							
35.	Felt down, depressed, or discouraged about future							
36.	Felt lonely, isolated, or withdrawn							
37.	Felt sad, tearful, or cried easily							
38.	Felt little interest or satisfaction in doing things							
39.	Felt irritable, annoyed, or resentful							
40.	Have self-critical, negative thoughts unable to stop							
41.	Number minutes engaged in physical exercise							
42.	Number of minutes in deep relaxation or meditation							
43.	Number of cigarettes smoked							
44.	Number of alcoholic drinks consumed							
45.	Number of hours experiencing some other symptom							
W	W = Went to Work or School							
M	M = Menstrual Period Occurred (for Women Only)							

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Side 2 **Form HDID-45**

Please describe below any personally significant or stressful events which occurred to you during each day of the week. Only note events which are not typical daily occurrences. Also list the name and the dosage of any medication you took that day. If you take the same medications every day, you may indicate an abbreviation for that medication and list only the abbreviation.

Day 1:

Day 2:

Day 3:

Day 4:

Day 5:

Day 6:

Day 7:

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Instructions for Health Distress Index and Health Distress Index Diary

Overview: The purpose of these two health surveys is to have you personally evaluate your typical symptoms of stress, pain, tension, and mood changes during the week. The Health Distress Index (HDI-40) survey asks you to evaluate 40 symptoms averaged over a whole week, whereas the Health Distress Index Diary (HDID-45) asks you to evaluate your experience on 45 items rated each day of the week for 7 consecutive days.

Ratings: For items #1 to #40, please rate your most typical daily experience for each of the items indicated, using a subjective rating scale which combines the degree, intensity, frequency and duration of that symptom. The numeric values of the rating are as follows :
"**4**" for a Highest Level of the presence of that symptom or experience;
"**3**" for a High Level of the presence of that symptom or experience;
"**2**" for a Moderate Level of the presence of that symptom or experience;
"**1**" for a Mild Level of the presence of that symptom or experience;
"___ " (leave blank) for None of that experience.

***Example Ratings* :** These items are very subjective. You should be compare your rating to the range of such experiences that you have had in your life. A rating of "4", for example, would be reserved for the worst time that you have ever had in either falling asleep or remaining asleep, the most severely painful headache or back pain that you have ever had, the most bothersome experience of feeling nervous or depressed that you can remember, or the best times of feeling good or working productively that you can remember.

Number of HDID Experiences: For items #41 to #45 on the Health Distress Index Diary (HDID-45), please show the number of minutes you engaged in that activity or the number of times you took that item.

Physical Exercise or Sports Activity for item #41 refers to any physical exercise, such as walking, jogging, going to the gym, or playing a sport. Indicate whether you spent 2 hours engaged in strenuous physical exercise or athletics or you spent even 15 minutes of doing light exercise.

Deep Relaxation or Meditation for item #42 refers to any deep relaxation technique or meditation process that you do with your eyes closed. It includes practices such as abdominal breathing, progressive relaxation, guided imagery, autogenic training, self-hypnosis, prayer, or transcendental meditation. Indicate if during the day you spent 60 minutes engaged in a deep relaxation process, or that you spent just 10 minutes where you took the time to deeply relax. It does not include open eyed activities such as watching television or reading a book.

Number of Cigarettes or Alcoholic Drinks for item #43 and #44 refers to the total number of cigarettes smoked that day or the total number of drinks consumed that day. One drink could be a can of beer, a glass of wine, a shot of liquor, or an alcoholic cocktail.

Number of Hours of Some Symptom for item #45 refers to the number of hours each day that you experienced a specific symptom that bothers you. Identify the symptom at the bottom of the page. This symptom could include the number of hours inebriated by alcohol, "high" on a drug, "craving" a chemical substance, skin irritation, menstrual or menopausal symptoms, or generalized body aches. The symptoms identified in item #45 should focus on experiences not already covered in items #1 to #40.

Work and Menstruation: For item "**W**" on the HDID-45, show the days you went to work or school during the past week by placing a "W" in that column. Item "**M**" is to be only filled out by women. Please show which days that you experienced your menstrual period over the past week, if at all, by placing an "M" in that column.

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