

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
(Month/Day/Year)

Sex ☐ Female  
☐ Male

Race ☐ White  
☐ Asian  
☐ Other Pacific Islander or Native Hawaiian  
☐ Black  
☐ American Indian or Alaska Native

Do you consider yourself Latino/Hispanic ethnicity? ☐ Yes  
☐ No

Highest education attained ☐ Some school but did not graduate high school  
☐ High school graduate or certificate of equivalency  
☐ Associate degree  
☐ Bachelor's degree  
☐ Master's degree  
☐ Doctorate degree

(select all that apply)

Have you been diagnosed with, treated, or monitored for a mood disorder? depression, anxiety, PTSD ☐ No (none)  
☐ Depression  
☐ Anxiety  
☐ Post-traumatic stress disorder (PTSD)  
☐ Other: \_\_\_\_\_

Research is growing in the potential for psychedelics to help treat conditions like anxiety, depression, and existential suffering. If you have experienced any of these issues, would you be interested in treatment with psychedelic therapy? ☐ Yes  
☐ No  
☐ Not sure

(select all that apply)

If "no" or "not sure", why not? ☐ Not interested  
☐ Need more information  
☐ It would not work  
☐ Do not want to use drugs  
☐ Do not want to use psychedelics  
☐ No need  
☐ Contraindicated for me  
☐ Fear of a bad trip  
☐ Other: \_\_\_\_\_

Do you have any other concerns or objections to using psychedelics? ☐ No  
☐ Yes: \_\_\_\_\_

(select all that apply)

- ☐ No (none)
- ☐ LSD
- ☐ Psilocybin/magic mushrooms
- ☐ MDMA
- ☐ Ketamine
- ☐ Mescaline/peyote
- ☐ DMT/ayahuasca
- ☐ Salvia
- ☐ MDA/sassafras
- ☐ Other:

Have you ever used psychedelics in the past?

Read each item below and mark the reply which comes closest to how you have been feeling in the **past week.**

|                                                                       | Very Poor |   |   |   |   |   | Excellent |
|-----------------------------------------------------------------------|-----------|---|---|---|---|---|-----------|
| How would you rate your overall health during the past week?          | 1         | 2 | 3 | 4 | 5 | 6 | 7         |
|                                                                       | Very Poor |   |   |   |   |   | Excellent |
| How would you rate your overall quality of life during the past week? | 1         | 2 | 3 | 4 | 5 | 6 | 7         |

|                                                                             |                                  |                                     |                                       |                                 |
|-----------------------------------------------------------------------------|----------------------------------|-------------------------------------|---------------------------------------|---------------------------------|
| I feel tense or 'wound up'                                                  | Not at all                       | From time to time, occasionally     | A lot of the time                     | Most of the time                |
| I still enjoy the things I used to enjoy                                    | Definitely as much               | Not quite so much                   | Only a little                         | Hardly at all                   |
| I get a sort of frightened feeling as if something awful is about to happen | Not at all                       | A little, but it doesn't worry me   | Yes, but not too badly                | Very definitely and quite badly |
| I can laugh and see the funny side of things                                | As much as I always could        | Not quite so much now               | Definitely not so much now            | Not at all                      |
| Worrying thoughts go through my mind                                        | Only occasionally                | From time to time but not too often | A lot of the time                     | A great deal of the time        |
| I feel cheerful                                                             | Most of the time                 | Sometimes                           | Not often                             | Not at all                      |
| I can sit at ease and feel relaxed                                          | Definitely                       | Usually                             | Not often                             | Not at all                      |
| I feel as if I am slowed down                                               | Not at all                       | Sometimes                           | Very often                            | Nearly all the time             |
| I get a sort of frightened feeling like 'butterflies' in the stomach        | Not at all                       | Occasionally                        | Quite often                           | Very often                      |
| I have lost interest in my appearance                                       | I take just as much care as ever | I may not take quite as much care   | I don't take so much care as I should | Definitely                      |
| I feel restless as if I have to be on the move                              | Not at all                       | Not very much                       | Quite a lot                           | Very much indeed                |
| I look forward with enjoyment to things                                     | As much as ever I did            | Rather less than I used to          | Definitely less than I used to        | Hardly at all                   |
| I get sudden feelings of panic                                              | Not at all                       | Not very often                      | Quite often                           | Very often indeed               |
| I can enjoy a good book or radio or TV program                              | Often                            | Sometimes                           | Not Often                             | Very seldom                     |

|                                                                   | Not at all               | A little bit             | Somewhat                 | Quite a bit              | Very much                |
|-------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| I feel peaceful                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have a reason for living                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My life has been productive                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have trouble feeling peace of mind                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel a sense of purpose in my life                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I am able to reach down deep into myself for comfort              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel a sense of harmony within myself                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My life lacks meaning and purpose                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I find comfort in my faith or spiritual beliefs                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I find strength in my faith or spiritual beliefs                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My illness has strengthened my faith or spiritual beliefs         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I know that whatever happens with my illness, things will be okay | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|                                                                                                       | Not at All               | A Little                 | Quite a Bit              | Very Much                |
|-------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Do you have any trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any trouble taking a long walk?                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any trouble taking a short walk outside of the house?                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you need to stay in bed or a chair during the day?                                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you need help with eating, dressing, washing yourself or using the toilet?                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Were you limited in doing either your work or other daily activities?                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Were you limited in pursuing your hobbies or other leisure time activities?                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you feel tense?                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you worry?                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you feel irritable?                                                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you feel depressed?                                                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had difficulty in concentrating on things, like reading a newspaper or watching television?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had difficulty remembering things?                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your physical condition or medical treatment interfered with your family life?                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your physical condition or medical treatment interfered with your social activities?              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|                                                                                                   |            |              |              |             |                   |
|---------------------------------------------------------------------------------------------------|------------|--------------|--------------|-------------|-------------------|
| How OFTEN did you have PAIN?                                                                      | Never      | Rarely       | Occasionally | Frequently  | Almost Constantly |
| What was the SEVERITY of your PAIN at its WORST?                                                  | None       | Mild         | Moderate     | Severe      | Very Severe       |
| How much did PAIN INTERFERE with your usual or daily activities?                                  | Not at all | A little bit | Somewhat     | Quite a bit | Very much         |
| What was the SEVERITY of your FATIGUE, TIREDNESS, OR LACK OF ENERGY at its WORST?                 | None       | Mild         | Moderate     | Severe      | Very Severe       |
| How much did FATIGUE, TIREDNESS, OR LACK OF ENERGY INTERFERE with your usual or daily activities? | Not at all | A little bit | Somewhat     | Quite a bit | Very much         |

Read each item below and circle the reply which comes closest to how you have been feeling in the **past 2 weeks.**

|                                                  | Never                    | Sometimes                | Often                    |
|--------------------------------------------------|--------------------------|--------------------------|--------------------------|
| There is little value in what I can offer others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My life seems to be pointless                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My role in life has been lost                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I no longer feel emotionally in control          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| No one can help me                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel that I cannot help myself                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel hopeless                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel irritable                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I do not cope well with life                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have a lot of regret about my life             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I tend to feel hurt easily                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel distressed about what is happening to me  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I am not a worthwhile person                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I would rather not be alive                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel quite isolated or alone                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel trapped by what is happening to me        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |