BASIS-24® (Behavior And Symptom Identification Scale)
ADULT VERSION

Instructions to Staff: Please fill in the following information completely.

Client ID: __ __ __ __ __ __ __ __ __ __

HCO ID: __ __ __ __

Admission / Intake Date: __ __ /__ __/__ __

Time Point:

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

Level of Care:

1☐ Inpatient
2☐ Outpatient
3☐ Partial/day hospital
4☐ Residential

Program Type or Unit: __ __

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…**		**No difficulty**	**A little difficulty**	**Moderate difficulty**	**Quite a bit of difficulty**	**Extreme difficulty**
Ex	Sleeping?	☐	☐	☑	☐	☐

During the PAST WEEK, how much difficulty did you have…		**No difficulty**	**A little difficulty**	**Moderate difficulty**	**Quite a bit of difficulty**	**Extreme difficulty**
1	Managing your day-to-day life?	☐	☐	☐	☐	☐
2	Coping with problems in your life?	☐	☐	☐	☐	☐
3	Concentrating?	☐	☐	☐	☐	☐

During the PAST WEEK, how much of the time did you…		**None of the time**	**A Little of the time**	**Half of the time**	**Most of the time**	**All of the time**
4	Get along with people in your family?	☐	☐	☐	☐	☐
5	Get along with people outside your family?	☐	☐	☐	☐	☐
6	Get along well in social situations?	☐	☐	☐	☐	☐
7	Feel close to another person?	☐	☐	☐	☐	☐
8	Feel like you had someone to turn to if you needed help?	☐	☐	☐	☐	☐
9	Feel confident in yourself?	☐	☐	☐	☐	☐

During the PAST WEEK, how much of the time did you…		**None of the time**	**A Little of the time**	**Half of the time**	**Most of the time**	**All of the time**
10	Feel sad or depressed?	☐	☐	☐	☐	☐
11	Think about ending your life?	☐	☐	☐	☐	☐
12	Feel nervous?	☐	☐	☐	☐	☐

***During the PAST WEEK,* how often did you…**		**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
13	Have thoughts racing through your head?	☐	☐	☐	☐	☐
14	Think you had special powers?	☐	☐	☐	☐	☐
15	Hear voices or see things?	☐	☐	☐	☐	☐
16	Think people were watching you?	☐	☐	☐	☐	☐
17	Think people were against you?	☐	☐	☐	☐	☐

TURN PAGE

During the PAST WEEK, how often did you…		Never	Rarely	Sometimes	Often	Always
18	Have mood swings?	☐	☐	☐	☐	☐
19	Feel short-tempered?	☐	☐	☐	☐	☐
20	Think about hurting yourself?	☐	☐	☐	☐	☐

During the *PAST WEEK*, how often…		Never	Rarely	Sometimes	Often	Always
21	Did you have an urge to drink alcohol or take street drugs?	☐	☐	☐	☐	☐
22	Did anyone talk to you about your drinking or drug use?	☐	☐	☐	☐	☐
23	Did you try to hide your drinking or drug use?	☐	☐	☐	☐	☐
24	Did you have problems from your drinking or drug use?	☐	☐	☐	☐	☐

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? (Select one.)
1☐American Indian or Alaskan native
2☐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 you now…
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? (Select all that apply.)
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? (Select all that apply.)
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 week

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
4☐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!

To Be Completed By Hospital Staff

Program Type (Select one):
1☐ General adult
2☐ Child/adolescent
3☐ Geriatric
4☐ Affective/mood disorders
5☐ Psychotic disorders
6☐ Anxiety disorders/trauma
7☐ Substance abuse/chemical dependency/trauma
8☐ Dual diagnosis
9☐ Other (fill in) _____

Primary Payer:
1☐ Self pay
2☐ BC/BS
3☐ Medicaid
4☐ Medicare
5☐ Commercial
6☐ Uninsured Primary payer:

Managed Care/HMO:
1☐ Yes
2☐ No
3☐ Unknown Managed Care/HMO:

Diagnosis	
GAF (1 to 100)	
Primary Diagnosis	
Secondary Diagnosis	
Tertiary Diagnosis	
AXIS IIa	
AXIS IIb	

Does patient have a medical condition requiring ongoing treatment?
1☐ Yes
2☐ No
3☐ Unknown

AXIS IV (Select all that apply):
1☐ Problems with primary support group
2☐ Problems related to the social environment
3☐ Educational problems
4☐ Occupational problems
5☐ Housing problems
6☐ Economic problems
7☐ Problems with access to health care services
8☐ Problems related to interaction with the legal system/crime
9☐ Other psychosocial and environmental problems
10☐ Not available