Hallucinations Rating Scale

Applicant Name: Date:	
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Instructions: For each item below, rate the applicant's experiences on a scale of 0-5. Include any additional notes or comments in the designated column. Ensure to respect privacy and maintain confidentiality.

Item No.	Assessment Area	Description	Rating (0-5)	Notes & Comments
1	Frequency	How often do the hallucinations occur?		
2	Duration	How long do the hallucinations typically last?		
3	Intensity	How intense or vivid are the hallucinations?		
4	Distress Level	How distressing are the hallucinations?		
5	Interference	How much do they interfere with daily activities?		
6	Reactivity	How often do you react to the hallucinations?		
7	Location	Where do they seem to originate (e.g., inside head, external)?		
8	Content Type	What type are they mainly (e.g., voices, visions, tactile)?		
9	Emotional Response	What emotions do the hallucinations evoke (e.g., fear, sadness)?		
10	Sleep Disturbance	Do they affect sleep?		
11	Clarity	How clear are the hallucinations?		

12	Recognition	Are they recognized as unreal or believed to be real?	
13	Content Nature	Are they commanding, threatening, neutral, or comforting?	
14	Triggers	Are there known triggers (e.g., stress, places, people)?	
15	Coping Strategies	Are there strategies used to cope with or manage them?	
16	Medication Influence	How do medications influence them (if applicable)?	
17	Sensory Modality	Which senses are involved (e.g., auditory, visual, tactile)?	
18	External Factors	Are there external factors that enhance/worsen them (e.g., lighting)?	
19	Temporal Pattern	When do they usually occur (e.g., night, morning, randomly)?	
20	Past Interventions	Were there past interventions? How effective were they?	

Rating Scale:

0: Not at all / Never	3: Sometimes / Moderate
1: Rarely / Very mild	4: Often / Moderately severe
2: Occasionally / Mild	5: Constantly / Very severe

Further comments/observations:							