Project New Day

Initial Screening Survey

Block: Consent

1. Project New Day has created the following survey for the sole purpose of determining eligibility for receiving psilocybin services and accompanying pre-session and post-session therapy. Before you begin, PLEASE NOTE that the entire survey may take as long as 15 minutes to complete. Your responses will be saved throughout the process, so you may step away and return to the survey as it is convenient for you. Would you like to respond to the following survey to see if you qualify for Project New Day services?

- Yes
- No

If 'No', Go to End of the form

2. We will be collecting information about you during this survey. Your taking part in this survey is completely voluntary. Your information will only be seen by staff at Project New Day. We try to make sure that the information we collect from you is kept private and used only for the purpose of determining eligibility for PND services.

Before continuing with this survey, let us first outline the process and services offered by Project New Day. Please understand this is the first phase of five in the screening and acceptance procedures. This survey collects information about you voluntarily for determining eligibility for PND services. Your information will be kept private. PND's five-step screening and acceptance procedure places safety above all else, with a thorough screening process lasting a few weeks. This includes the following survey, two Zoom interviews, a final contact with a PND coach, and a psychological and physiological evaluation with a licensed physician. After six weekly life-coaching sessions, participants receive two psychedelic sessions, separated by another life-coaching session. The psychedelic sessions are followed by six more life coaching sessions, helping participants integrate their experiences into their daily lives. The entire process lasts 15 weeks and includes support through PND's online communities.

After reading the above description of the PND Program would you like to continue with the first step in the screening process?

- Yes

If ‘Yes’, Go to Next

- No

If ‘No’, Go to End of the form

Block: Demographics

3. Where did you hear about Project New Day?

- Physician Referral
- Friend or Family
- Netflix
- Newspaper/Magazine
- Radio
- Podcast
- TV
- Other

4. First name

- Open-ended response.

5. Last name

- Open-ended response.

6. Address

- Open-ended response.

7. City

- Open-ended response.

8. State

- Open-ended response.

9. Postal code

- Open-ended response.

10. Phone number

- Open-ended response.

11. Email address

- Open-ended response.

12. Confirm Email address
    - Open-ended response.
13. How do you identify
    - Male
    - Female
    - Transgender (Male to Female)
    - Transgender (Female to Male)
    - Gender-fluid
    - Non-binary/gender queer
    - Questioning or unsure
    - Other
14. What is your age?
    - Open-ended response.
15. What is your current marital status?
    - Married
    - Separated
    - Divorced
    - Widowed
    - Engaged
    - Partnered
    - Single
    - Other
16. Do you live with the person you are married to or partnered with?
    - Yes
    - No
    - N/A
17. How many children do you have?
    - None - 9+

Block: OHA Criteria

18. Have you taken the prescription drug Lithium in the last 30 days?

- Yes
- No

19. Are you breastfeeding, pregnant, or intending to become pregnant in the next six months?

- Yes
- No

20. Have you ever experienced a psychotic episode or been treated for active psychosis?

- Yes
- No

21. Have you been diagnosed with schizophrenia, bipolar disorder or a personality disorder?

- Yes
- No

22. Are you having thoughts of causing harm, or wanting to cause harm to yourself or others?

- Yes
- No

23. Do you have a history of causing harm, or wanting to cause harm, to yourself or others?

- Yes
- No

24. Please share details regarding your history of causing, or wanting to cause harm, to self or others.

- Open-ended response.

25. Do you have any cardiovascular conditions?

- Yes
- No

26. Have you ever had a seizure?

- Yes
- No

27. Have you been diagnosed with renal disease?

- Yes
- No

28. Do you have insulin-dependent diabetes?

- Yes
- No

29. Do you have high blood pressure?

- Yes
- No

30. Are you taking medication to manage your high blood pressure?

- Yes
- No

31. Are there any first-degree relatives (children, parents, or siblings) in your family who have ever been diagnosed with schizophrenia, bipolar, or other psychotic disorder?

- Yes
- No

Block: Diagnostic (ACE Measure)

32. Researchers determined that 10 specific traumatic childhood experiences, or ACEs, could be linked to a higher likelihood of health challenges later in life, and that the likelihood of these negative effects increased with the number of “ACEs” a child experienced.

Please refer to the list below and indicate how many of the following adverse events you have experienced before turning the age of 18. For each "yes" answer, add 1 to your total response.

1. Did a parent or other adult in the household often or very often… swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?

2. Did a parent or other adult in the household often or very often… push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?

3. Did an adult or person at least 5 years older than you ever… touch or fondle you or have you touch their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?

5. Did you often or very often feel that … you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6. Were your parents ever separated or divorced?

7. Was your mother or stepmother:

   Often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

10. Did a household member go to prison?

- 0-17

Block: Diagnostic (CAGE)

33. Have you ever felt you ought to cut down on your drinking or drug use?

- Yes
- No

34. Have people annoyed you by criticizing your drinking or drug use?

- Yes
- No

35. Have you felt bad or guilty about your drinking or drug use?

- Yes
- No

36. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

- Yes
- No

Block: Diagnostic (K-10)

37. In the last 30 days, how often did you feel...

	All of the time	*Most of the time*	*Some of the time*	*A little of the time*	*None of the time*
...Tired out for no good reason?					
...Nervous?					

...So nervous that nothing could calm you down?					
...Hopeless?					
...Restless or fidgety?					
...So restless that you could not sit still?					
...Depressed?					
...So depressed that nothing could cheer you up?					
...That everything was an effort?					
...Worthless?					

38. The last ten questions asked about feelings that might have occurred during the past 30 days. Taking them all together, did these feelings occur more often in the past 30 days than is usual for you, about the same as usual, or less often than usual? (If you never have any of these feelings, select "About the same as usual.")

	Much more often than usual	*More often than usual*	*Slightly more often than usual*	*About the same as usual*	*Slightly less often than usual*	*Less often than usual*	*Much less often than usual*
These feelings have occurred...							

39. During the past 30 days, how many days out of 30 were you totally unable to work or carry out your normal activities because of these feelings?

- 0-30

40. Not counting the days you reported in response to Q3, how many days in the past 30 were you able to do only half or less of what you would normally have been able to do, because of these feelings?

- 0-30

41. During the past 30 days, how many times did you see a doctor or other health professional about these feelings?

- 0-30

42. During the past 30 days, how often have physical health problems been the main cause of these feelings?

	All of the time	*Most of the time*	*Some of the time*	*A little of the time*	*None of the time*
My physical health has been the main cause...					

Block: Diagnostic (DAST-10)

43. Have you used drugs other than those required for medical reasons?

- Yes
- No

44. Do you abuse more than one drug at a time?

- Yes
- No

45. Are you always able to stop using drugs when you want to? (If never use drugs, select “Yes.”)

- Yes

- No

46. Have you had "blackouts" or "flashbacks" as a result of drug use?

- Yes
- No

47. Do you ever feel bad or guilty about your drug use? (If you never have used drugs, select “No.”)

- Yes
- No

48. Does your spouse (or parents) ever complain about your involvement with drugs?

- Yes
- No

49. Have you neglected your family because of your use of drugs?

- Yes
- No

50. Have you engaged in illegal activities in order to obtain drugs?

- Yes
- No

51. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?

- Yes
- No

52. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?

- Yes
- No

Block: Conclusion

Thank you for completing this survey. Staff at PND will review your responses so they may fully determine your eligibility. You will be contacted via email with a decision and information regarding next steps within the next few weeks. We at Project New Day appreciate the time you have spent completing this survey and ask that you feel free to contact our staff via email with any question, comments, or concerns. Our email address is info@projectnewday.foundation.
Thank you!