Patient's Name: ______________________________

Today's Date: ______________________________

Please review the following checklist. Check the ones that **you are** experiencing:

____ Disrupted eating pattern (too much or not enough)

____ Disrupted sleeping pattern (too much or not enough)

____ Crying

____ Sadness

____ Low energy level

____ Fatigue

____ Low motivation

____ Low self-esteem

____ Poor Concentration

____ Difficulty making decisions

____ Hopelessness

____ Headaches

____ Nausea / Stomachaches

____ Nervousness

____ Fearfulness

____ Mood Swings

____ Anger

____ High energy level

____ Impulsiveness

____ Easily Distracted

____ Racing thoughts

____ Difficulty in school / work

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____ Helplessness

____Decreased interest in activities

____ Thoughts of hurting self

____ Thoughts of hurting others

____ Irritability

____ Overwhelmed

____ Frustration

____ Excessive worrying

____ Restlessness

____ Muscle tension

____ Panic attacks

____ Isolation

____ Difficulty following directions

____ Difficulty completing tasks

____ Poor organization

____ Forgetfulness

____ Fidgeting

____ Difficulty remaining seated

____ Impatience

____ Procrastination

____ Talking excessively

____ Interrupting

____ Becoming bored easily

____ Losing items

____ Nightmares

____ Flashbacks

Checklist completed by: ______________________________ **Date:** ___________

Reviewed by: ____**Date:**__________

Substance Uses:

Alcohol:

- **Last time used:**______________________________
- **Amount:**______________________________
- **Frequency:**______________________________
- **Types used:**______________________________

Drugs (anything that is not prescribed to you):

- **Last time used:**______________________________
- **Amount:**______________________________
- **Frequency:**______________________________
- **Types used:**______________________________

***Please answer YES or NO to the following questions:**

- **Have you ever felt that you should cut down on your drinking?** ________
- **Have people ever annoyed you by criticizing your drinking?** ________
- **Have you ever felt bad or guilty about your drinking?** ________
- **Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?** ________

CIDI Screener

Name:__________________________________Date: ____________ Date of birth: ___/___/___

Instructions: Please check **YES** or **NO** to the following questions

#	Questions	YES	NO
	Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast, they talk a lot. They are very restless or unstable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money.		
1	Have you ever had a period like this lasting several days or longer? (if you selected YES, skip question 2)		
2	Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you started arguments, shouted at people, or hit people?		
	If you answered NO to questions 1 and 2 you do not need to complete the following questions.		
3	People who have episode like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and heaving in many ways they would normally think inappropriate. Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy?		
	If you answered NO to question 3 you do not need to complete the following questions.		
	Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?		
1	Were you so irritable that you started arguments, shouted at people, or hit people? (this question is asked only if the first question above is endorsed)		
2	Did you become so restless or fidgety that you paced up and down or couldn't stand still?		
3	Did you do anything else that wasn't usual for you – like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?		
4	Did you try to do things that were impossible to do, like taking on large amounts of work?		
5	Do you constantly keep changing your plans or activities?		
6	Did you find it hard to keep your mind on what you were doing?		
7	Did your thoughts seem to jump from one thing to another or race through your head to fast you couldn't keep track of them?		
8	Did you sleep far less than usual and still not get tired or sleepy?		
9	Did you spend so much more money than usual that it caused you to have financial trouble?		

Permission to use by The World Health Organization's Composite International Diagnostic Interview (WHO CIDI, 1990)

Patient Health Questionnaire (PHQ-9)

Name ______________________________ Date of Birth ______________________________

OVER THE LAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	Not at all	Several Days	More than Half	Nearly Every Day
Little interest of pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless?	0	1	2	3
Trouble falling, or staying asleep? Sleeping too much?	0	1	2	3
Feeling tired or having little or no energy?	0	1	2	3
Poor appetite or over-eating?	0	1	2	3
Feeling bad about yourself-or that you are a failure? Feeling that you have let yourself or your family down?	0	1	2	3
Trouble concentrating on things such as the TV or newspaper?	0	1	2	3
Moving or speaking so slowly that others could notice? Or being so fidgety or restless / moving around more than normal?	0	1	2	3
Thoughts you would be better off dead, or of hurting yourself?	0	1	2	3

Total

(HEALTHCARE PROFESSIONSALS: For interpretation on TOTAL refer to accompanying score card)

If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with others?

- Not Difficult ☐
- Somewhat difficult ☐
- Verv Difficult ☐

GAD-7

Over the **last 2 weeks**, how often have you been bothered by the following problems? *(use " ✓ " to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen?	0	1	2	3

(For office coding: Total Score T _______ = _______ + _______ + _______ **)**

Developed by Drs. Robert L Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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PCL-6 Screener

Name: ______________________ Date: ____________ Date of birth: ___/___/___

Instructions: Below is a list of problems and complaints that individuals sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem ***in the last month.***

#	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1	Repeated, disturbing, memories, thoughts, or images of the stressful experience from the past?					
2	Feeling very upset when something reminded you of a stressful experience from the past?					
3	Avoid activities or situations because they remind you of a stressful experience from the past?					
4	Feeling distant or cut off from other people?					
5	Feeling irritable or having angry outbursts?					
6	Having difficulty concentrating?					

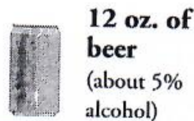
PCL-6 (January, 2013). Permission to use by The National Center for PTSD

AUDIT

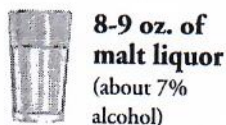
PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

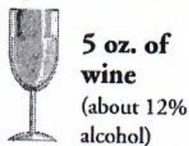
NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:



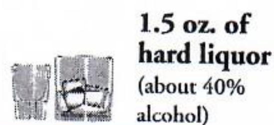
12 oz. of beer (about 5% alcohol) =



8-9 oz. of malt liquor (about 7% alcohol) =



5 oz. of wine (about 12% alcohol) =



1.5 oz. of hard liquor (about 40% alcohol)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at ***www.who.org***.

DAST-10 Screener

Name:___________________________ Date: ____________ Date of birth: ___/___/___

This is a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months. When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin).

If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months…	**Circle**
1. Have you used drugs other than those required for medical reasons?	Yes No
2. Do you abuse more than one drug at a time?	Yes No
3. Are you unable to stop abusing drugs when you want to?	Yes No
4. Have you ever had blackouts or flashbacks as a result of drug use?	Yes No
5. Do you ever feel bad or guilty about your drug use?	Yes No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes No
7. Have you neglected your family because of your use of drugs?	Yes No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes No
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes No

Copyright: Skinner, H. A. (1982). The Drug Abuse Screening Test. Addictive Behavior, 7(4),363–371.