# Patient Health Questionnaire (PHQ-9)

| Over the past **2 weeks**, how often have you been bothered by any of the following problems? Circle the response that best describes how you have been feeling. | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things: | 0 | 1 | 2 | 3 |
| 2. Felling down, depressed or hopeless: | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep or sleeping too much: | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy: | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating: | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself or that you are a failure or have let yourself or your family down: | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television: | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than normal: | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself: | 0 | 1 | 2 | 3 |

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

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

## Generalized Anxiety Disorder 7-item (GAD-7) scale

| Over the past **2 weeks**, how often have you been bothered by the following problems? | Not at all | Several days | Over 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's 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 |

If you 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 other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

# The Alcohol Use Disorders Identification Test: Self Report Version

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. Circle the response that best describes your answer to each question.

| | | | | | |
|---|---|---|---|---|---|
| 1. How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 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 six 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 you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 9. Have you or someone else been injured as a result of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year |
| 10. Has a relative or friend or a doctor or another 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 |

# Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible invovlement with drugs *excluding alcohol and tobacco,* during the past **12 months.**

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD), or narcotics (e.g., heroin). Remember that the questions *do not* include alcohol or tobacco.

Please answer every question. 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 always able to stop using drugs when you want to? (If never use drugs, answer "Yes") | Yes | No |
| 4. Have you had "blackouts" or "flashbacks" as a result of drug use? | Yes | No |
| 5. Do you ever feel bad or guilty about your drug use? (If never use drugs, choose "No.") | 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, etc.)? | Yes | No |

## PTST CheckList - Civilian Version (PCL-C)

Below is a list of problems and complaints that sometimes occur in response to stressful life experiences. Please read each one carefully and select the response that best describes your answer:

In the ***last month*** , how much have you been bothered by:

| | | | | | |
|---|---|---|---|---|---|
| 1. Repeated, distrubing *memories* , *thoughts* , or *images* of a stressful experience from the past? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 2. Repeated, distrubing *dreams* of a stressful experience from the past? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 3. Suddenly *acting* or *feeling* as if a stressful experience were *happening* again (as if you were reliving it)? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 4. Feeling very upset when *something reminded* you of a stressful experience from the past? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 5. Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 7. Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 8. Trouble *remembering important parts* of a stressful experience from the past? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 9. Loss of *interest in things* that you used to enjoy? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 10. Feeling *distant* or *cut off* from other people? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 11. Feeling *emotionally numb* or being unable to have loving feelings for those close to you? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 12. Feeling as if your *future* will somehow be *cut short* ? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 13. Trouble *falling* or *staying* asleep? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 14. Feeling *irritable* or having *angry* outbursts? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 15. Having *difficulty concentrating?* | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 16. Being "*super alert*" or watchful on guard? | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 17. Feeling *jumpy* or easily startled? | Not at all | A little bit | Moderately | Quite a bit | Extremely |