PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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. Feeling 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 figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 _____

A2663B 10-04-2005

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

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Name:_____ Date:_____

Panic Disorder Severity Scale – Self Report Form

Several of the following questions refer to panic attacks and limited symptom attacks. For this questionnaire we define a panic attack as a sudden rush of fear or discomfort accompanied by at least 4 of the symptoms listed below. In order to qualify as a sudden rush, the symptoms must peak within 10 minutes. Episodes like panic attacks but having fewer than 4 of the listed symptoms are called limited symptom attacks. Here are the symptoms to count:

- Rapid or pounding heartbeat
- Sweating
- Trembling or shaking
- Breathlessness
- Feeling of choking
- Chest pain or discomfort
- Nausea
- Dizziness or faintness
- Feelings of unreality
- Numbness or tingling
- Chills or hot flushes
- Fear of losing control or going crazy
- Fear of dying

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1. How many panic and limited symptoms attacks did you have during the week?

   0 No panic or limited symptom episodes
   1 Mild: no full panic attacks and no more than 1 limited symptom attack/day
   2 Moderate: 1 or 2 full panic attacks and/or multiple limited symptom attacks/day
   3 Severe: more than 2 full attacks but not more than 1/day on average
   4 Extreme: full panic attacks occurred more than once a day, more days than not

2. If you had any panic attacks during the past week, how distressing (uncomfortable, frightening) were they while they were happening? (If you had more than one, give an average rating. If you didn't have any panic attacks but did have limited symptom attacks, answer for the limited symptom attacks.)

   0 Not at all distressing, or no panic or limited symptom attacks during the past week
   1 Mildly distressing (not too intense)
   2 Moderately distressing (intense, but still manageable)
   3 Severely distressing (very intense)
   4 Extremely distressing (extreme distress during all attacks)

3. During the past week, how much have you worried or felt anxious about when your next panic attack would occur or about fears related to the attacks (for example, that they could mean you have physical or mental health problems or could cause you social embarrassment)?

   0 Not at all
   1 Occasionally or only mildly
   2 Frequently or moderately
   3 Very often or to a very disturbing degree
   4 Nearly constantly and to a disabling extent

4. During the past week were there any places or situations (e.g., public transportation, movie theaters, crowds, bridges, tunnels, shopping malls, being alone) you avoided, or felt afraid of (uncomfortable in, wanted to avoid or leave), because of fear of having a panic attack? Are there any other situations that you would have avoided or been afraid of if they had come up during the week, for the same reason? If yes to either question, please rate your level of fear and avoidance this past week.

   0 None: no fear or avoidance
   1 Mild: occasional fear and/or avoidance but I could usually confront or endure the situation. There was little or no modification of my lifestyle due to this.
   2 Moderate: noticeable fear and/or avoidance but still manageable. I avoided some situations, but I could confront them with a companion. There was some modification of my lifestyle because of this, but my overall functioning was not impaired.
   3 Severe: extensive avoidance. Substantial modification of my lifestyle was required to accommodate the avoidance making it difficult to manage usual activities.
   4 Extreme: pervasive disabling fear and/or avoidance. Extensive modification in my lifestyle was required such that important tasks were not performed.

5. During the past week, were there any activities (e.g., physical exertion, sexual relations, taking a hot shower or bath, drinking coffee, watching an exciting or scary movie) that you avoided, or felt afraid of (uncomfortable doing, wanted to avoid or stop), because they caused physical sensations like those you feel during panic attacks or that you were afraid might trigger a panic attack? Are there any other activities that you would have avoided or been afraid of if they had come up during the week for that reason? If yes to either question, please rate your level of fear and avoidance of those activities this past week.

   0 No fear or avoidance of situations or activities because of distressing physical sensations
   1 Mild: occasional fear and/or avoidance, but usually I could confront or endure with little distress activities that cause physical sensations. There was little modification of my lifestyle due to this.
   2 Moderate: noticeable avoidance but still manageable. There was definite, but limited, modification of my lifestyle such that my overall functioning was not impaired.
   3 Severe: extensive avoidance. There was substantial modification of my lifestyle or interference in my functioning.
   4 Extreme: pervasive and disabling avoidance. There was extensive modification in my lifestyle due to this such that important tasks or activities were not performed.

6. During the past week, how much did the above symptoms altogether (panic and limited symptom attacks, worry about attacks, and fear of situations and activities because of attacks) interfere with your ability to work or carry out your responsibilities at home? (If your work or home responsibilities were less than usual this past week, answer how you think you would have done if the responsibilities had been usual.)

   0 No interference with work or home responsibilities
   1 Slight interference with work or home responsibilities, but I could do nearly everything I could if I didn't have these problems.
   2 Significant interference with work or home responsibilities, but I still could manage to do the things I needed to do.
   3 Substantial impairment in work or home responsibilities; there were many important things I couldn't do because of these problems.
   4 Extreme, incapacitating impairment such that I was essentially unable to manage any work or home responsibilities.

7. During the past week, how much did panic and limited symptom attacks, worry about attacks and fear of situations and activities because of attacks interfere with your social life? (If you didn't have many opportunities to socialize this past week, answer how you think you would have done if you did have opportunities.)

   0 No interference
   1 Slight interference with social activities, but I could do nearly everything I could if I didn't have these problems.
   2 Significant interference with social activities but I could manage to do most things if I made the effort.
   3 Substantial impairment in social activities; there are many social things I couldn't do because of these problems.
   4 Extreme, incapacitating impairment, such that there was hardly anything social I could do.

The Mood Disorder Questionnaire (MDQ)

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor. However, a positive screen here may suggest that you might benefit from seeking such an evaluation from your doctor. Regardless of the questionnaire results, if you or someone you know has concerns about your mental health, please contact your physician or another healthcare professional.

INSTRUCTIONS: Please answer each question as best you can.	**YES**	**NO**
1. Has there ever been a period of time when you were not your usual self and...		
... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	O	O
... you were so irritable that you shouted at people or started fights or arguments?	O	O
... you felt much more self-confident than usual?	O	O
... you got much less sleep than usual and found that you didn't really miss it?	O	O
... you were more talkative or spoke much faster than usual?	O	O
... thoughts raced through your head or you couldn't slow your mind down?	O	O
... you were so easily distracted by things around you that you had trouble concentrating or staying on track?	O	O
... you had much more energy than usual?	O	O
... you were much more active or did many more things than usual?	O	O
... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	O	O
... you were much more interested in sex than usual?	O	O
... you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	O	O
... spending money got you or your family in trouble?	O	O
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	O	O
3. How much of a problem did any of these cause you - like being able to work; having family, money or legal troubles; getting into arguments or fights?		
O No problem O Minor problem O Moderate problem O Serious problem		
4.* Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	O	O
5.* Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	O	O

*Derived from Hirschfeld RM. *Am J Psychiatry*. 2000:157(11):1873-5.

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PATIENT 22.

N**AME** **DATE**

YALE-BROWN OBSESSIVE COMPULSIVE SCALE (Y-BOCS)*

Questions 1 to 5 are about your obsessive thoughts

Obsessions are unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. They usually involve themes of harm, risk and danger. Common obsessions are excessive fears of contamination; recurring doubts about danger, extreme concern with order, symmetry, or exactness; fear of losing important things.

Please answer each question by circling the appropriate number.

1. TIME OCCUPIED BY OBSESSIVE THOUGHTS SCORE _____

How much of your time is occupied by obsessive thoughts?

0	=	None
1	=	Less than 1 hr/day or occasional occurrence
2	=	1 to 3 hrs/day or frequent
3	=	Greater than 3 and up to 8 hrs/day or very frequent occurrence
4	=	Greater than 8 hrs/day or nearly constant occurrence

2. INTERFERENCE DUE TO OBSESSIVE THOUGHTS SCORE _____

How much do your obsessive thoughts interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of them?

0	=	None
1	=	Slight interference with social or other activities, but overall performance not impaired
2	=	Definite interference with social or occupational performance, but still manageable
3	=	Causes substantial impairment in social or occupational performance
4	=	Incapacitating

3. DISTRESS ASSOCIATED WITH OBSESSIVE THOUGHTS SCORE _____

How much distress do your obsessive thoughts cause you?

0	=	None
1	=	Not too disturbing
2	=	Disturbing, but still manageable
3	=	Very disturbing
4	=	Near constant and disabling distress

4. RESISTANCE AGAINST OBSESSIONS SCORE _____

How much of an effort do you make to resist the obsessive thoughts? How often do you try to disregard or turn your attention away from these thoughts as they enter your mind?

0	=	Try to resist all the time
1	=	Try to resist most of the time
2	=	Make some effort to resist
3	=	Yield to all obsessions without attempting to control them, but with some reluctance
4	=	Completely and willingly yield to all obsessions

5. DEGREE OF CONTROL OVER OBSESSIVE THOUGHTS SCORE _____

How much control do you have over your obsessive thoughts? How successful are you in stopping or diverting your obsessive thinking? Can you dismiss them?

0	=	Complete control
1	=	Usually able to stop or divert obsessions with some effort and concentration
2	=	Sometimes able to stop or divert obsessions
3	=	Rarely successful in stopping or dismissing obsessions, can only divert attention with difficulty
4	=	Obsessions are completely involuntary, rarely able to even momentarily alter obsessive thinking.

The next several questions are about your compulsive behaviors.
Compulsions are urges that people have to do something to lessen feelings of anxiety or other discomfort. Often they do repetitive, purposeful, intentional behaviors called rituals. The behavior itself may seem appropriate but it becomes a ritual when done to excess. Washing, checking, repeating, straightening, hoarding and many other behaviors can be rituals. Some rituals are mental. For example, thinking or saying things over and over under your breath.

6. TIME SPENT PERFORMING COMPULSIVE BEHAVIORS SCORE _____

How much time do you spend performing compulsive behaviors? How much longer than most people does it take to complete routine activities because of your rituals? How frequently do you do rituals?

0	=	None
1	=	Less than 1 hr/day or occasional performance of compulsive behaviors
2	=	From 1 to 3 hrs/day, or frequent performance of compulsive behaviors
3	=	More than 3 and up to 8 hrs/day, or very frequent performance of compulsive behaviors
4	=	More than 8 hrs/day, or near constant performance of compulsive behaviors (too numerous to count)

7. INTERFERENCE DUE TO COMPULSIVE BEHAVIORS SCORE _____

How much do your compulsive behaviors interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of the compulsions?

0	=	None
1	=	Slight interference with social or other activities, but overall performance not impaired
2	=	Definite interference with social or occupational performance, but still manageable
3	=	Causes substantial impairment in social or occupational performance
4	=	Incapacitating

8. DISTRESS ASSOCIATED WITH COMPULSIVE BEHAVIOR SCORE _____

How would you feel if prevented from performing your compulsion(s)? How anxious would you become?

0 = None
1 = Only slightly anxious if compulsions prevented
2 = Anxiety would mount but remain manageable if compulsions prevented
3 = Prominent and very disturbing increase in anxiety if compulsions interrupted
4 = Incapacitating anxiety from any intervention aimed at modifying activity

9. RESISTANCE AGAINST COMPULSIONS SCORE _____

How much of an effort do you make to resist the compulsions?

0 = Always try to resist
1 = Try to resist most of the time
2 = Make some effort to resist
3 = Yield to almost all compulsions without attempting to control them, but with some reluctance
4 = Completely and willingly yield to all compulsions

10. DEGREE OF CONTROL OVER COMPULSIVE BEHAVIOR SCORE _____

How strong is the drive to perform the compulsive behavior? How much control do you have over the compulsions?

0 = Complete control
1 = Pressure to perform the behavior but usually able to exercise voluntary control over it
2 = Strong pressure to perform behavior, can control it only with difficulty
3 = Very strong drive to perform behavior, must be carried to completion, can only delay with difficulty
4 = Drive to perform behavior experienced as completely involuntary and over-powering, rarely able to even momentarily delay activity.

TOTAL SCORE _____

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans 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*.

No.	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 a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

Alcohol Use Disorders Identification Test (AUDIT)

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?

   (0) Never *[Skip to Qs 9-10]*
   (1) Monthly or less
   (2) 2-4 times a month
   (3) 2-3 times a week
   (4) 4 or more times a week

2. How many standard drinks do you have on a typical day when you are drinking?

   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7 to 9
   (4) 10 or more

3. How often do you have 6 or more drinks on one occasion?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

   Skip to Q9 and 10 if Total Score for Q 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) 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?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) 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?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

Questions 1-8 of the NIDA-Modified ASSIST V2.0

Instructions: Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

Question 1 of 8, NIDA-Modified ASSIST **In your *LIFETIME*, which of the following substances have you ever used?** ***Note for Physicians: For prescription medications, please report nonmedical use only.***	**Yes**	**No**
a. Cannabis (marijuana, pot, grass, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. Other – specify:		

- Given the patient's response to the Quick Screen, the patient *should not indicate* **"NO"** for all drugs in Question 1. If they do, remind them that their answers to the Quick Screen indicated they used an illegal or prescription drug for nonmedical reasons within the past year and then **repeat Question 1**. If the patient indicates that the drug used is not listed, please mark **'Yes'** next to 'Other' and continue to **Question 2** of the NIDA-Modified ASSIST**.**
- If the patient says **"Yes"** to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

Question 2 of 8, NIDA-Modified ASSIST 2. <u>In the past three months</u>, how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
• Cannabis (marijuana, pot, grass, hash, etc.)					
• Cocaine (coke, crack, etc.)					
• Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)					
• Methamphetamine (speed, crystal meth, ice, etc.)					
• Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)					
• Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)					
• Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)					
• Street opioids (heroin, opium, etc.)					
• Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)					
• Other – Specify:					

- For patients who report **"Never"** having used any drug in the past 3 months: **Go to Questions 6-8**.
- For any recent **illicit or nonmedical prescription drug use**, go to **Question 3.**

3. <u>In the past 3 months</u>, how often have you had a strong desire or urge to use (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)					
b. Cocaine (coke, crack, etc.)					
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)					
d. Methamphetamine (speed, crystal meth, ice, etc.)					
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)					
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)					
h. Street Opioids (heroin, opium, etc.)					
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)					
j. Other – Specify:					

4. During the past 3 months, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)					
b. Cocaine (coke, crack, etc.)					
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)					
d. Methamphetamine (speed, crystal meth, ice, etc.)					
e. Inhalants (nitrous oxide, glue, gas, pain thinner, etc.)					
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)					
h. Street opioids (heroin, opium, etc.)					
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)					
j. Other – Specify:					

5. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)					
b. Cocaine (coke, crack, etc.)					
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)					
d. Methamphetamine (speed, crystal meth, ice, etc.)					
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)					
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)					
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)					
h. Street Opioids (heroin, opium, etc.)					
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)					
j. Other – Specify:					

Instructions: Ask Questions 6 & 7 for all substances **ever used** (i.e., those endorsed in the Question 1).

6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)			
b. Cocaine (coke, crack, etc.)			
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)			
d. Methamphetamine (speed, crystal meth, ice, etc.)			
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)			
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)			
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)			
h. Street opioids (heroin, opium, etc.)			
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)			
j. Other – Specify:			

7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)			
b. Cocaine (coke, crack, etc.)			
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)			
d. Methamphetamine (speed, crystal meth, ice, etc.)			
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)			
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)			
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)			
h. Street opioids (heroin, opium, etc.)			
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)			
j. Other – Specify:			

Instructions: Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
  - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
  - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

Note: Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

The Quick Inventory of Depressive Symptomatology (16-Item) (Self-Report) (QIDS-SR16)

Name or ID: _____ Date: _____

CHECK THE ONE RESPONSE TO EACH ITEM THAT BEST DESCRIBES YOU FOR THE PAST SEVEN DAYS.

During the past seven days...

1. Falling Asleep:

☐ 0 I never take longer than 30 minutes to fall asleep.

☐ 1 I take at least 30 minutes to fall asleep, less than half the time.

☐ 2 I take at least 30 minutes to fall asleep, more than half the time.

☐ 3 I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep During the Night

☐ 0 I do not wake up at night.

☐ 1 I have a restless, light sleep with a few brief awakenings each night.

☐ 2 I wake up at least once a night, but I go back to sleep easily.

☐ 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. Waking Up Too Early:

☐ 0 Most of the time, I awaken no more than 30 minutes before I need to get up.

☐ 1 More than half the time, I awaken more than 30 minutes before I need to get up.

☐ 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.

☐ 3 I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping Too Much:

☐ 0 I sleep no longer than 7-8 hours/night, without napping during the day.

☐ 1 I sleep no longer than 10 hours in a 24-hour period including naps.

☐ 2 I sleep no longer than 12 hours in a 24-hour period including naps.

☐ 3 I sleep longer than 12 hours in a 24-hour period including naps.

During the past seven days...

5. Feeling Sad:

☐ 0 I do not feel sad.

☐ 1 I feel sad less than half the time.

☐ 2 I feel sad more than half the time.

☐ 3 I feel sad nearly all of the time.

Please complete either 6 or 7 (not both)

6. Decreased Appetite:

☐ 0 There is no change in my usual appetite.

☐ 1 I eat somewhat less often or lesser amounts of food than usual.

☐ 2 I eat much less than usual and only with personal effort.

☐ 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

- OR -

7. Increased Appetite:

☐ 0 There is no change from my usual appetite.

☐ 1 I feel a need to eat more frequently than usual.

☐ 2 I regularly eat more often and/or greater amounts of food than usual.

☐ 3 I feel driven to overeat both at mealtime and between meals.

Please complete either 8 or 9 (not both)

8. Decreased Weight (Within the Last Two Weeks):

☐ 0 I have not had a change in my weight.

☐ 1 I feel as if I have had a slight weight loss.

☐ 2 I have lost 2 pounds or more.

☐ 3 I have lost 5 pounds or more.

- OR -

9. Increased Weight (Within the Last Two Weeks):

☐ 0 I have not had a change in my weight.

☐ 1 I feel as if I have had a slight weight gain.

☐ 2 I have gained 2 pounds or more.

☐ 3 I have gained 5 pounds or more.

The Quick Inventory of Depressive Symptomatology (16-Item) (Self-Report) (QIDS-SR16)

During the past seven days...

10. Concentration / Decision Making:

- ☐ 0 There is no change in my usual capacity to concentrate or make decisions.
- ☐ 1 I occasionally feel indecisive or find that my attention wanders.
- ☐ 2 Most of the time, I struggle to focus my attention or to make decisions.
- ☐ 3 I cannot concentrate well enough to read or cannot make even minor decisions.

11. View of Myself:

- ☐ 0 I see myself as equally worthwhile and deserving as other people.
- ☐ 1 I am more self-blaming than usual.
- ☐ 2 I largely believe that I cause problems for others.
- ☐ 3 I think almost constantly about major and minor defects in myself.

12. Thoughts of Death or Suicide:

- ☐ 0 I do not think of suicide or death.
- ☐ 1 I feel that life is empty or wonder if it's worth living.
- ☐ 2 I think of suicide or death several times a week for several minutes.
- ☐ 3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

13. General Interest

- ☐ 0 There is no change from usual in how interested I am in other people or activities.
- ☐ 1 I notice that I am less interested in people or activities.
- ☐ 2 I find I have interest in only one or two of my formerly pursued activities.
- ☐ 3 I have virtually no interest in formerly pursued activities.

During the past seven days...

14. Energy Level:

- ☐ 0 There is no change in my usual level of energy.
- ☐ 1 I get tired more easily than usual.
- ☐ 2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking, or going to work).
- ☐ 3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling Slowed Down:

- ☐ 0 I think, speak, and move at my usual rate of speed.
- ☐ 1 I find that my thinking is slowed down or my voice sounds dull or flat.
- ☐ 2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
- ☐ 3 I am often unable to respond to questions without extreme effort.

16. Feeling Restless:

- ☐ 0 I do not feel restless.
- ☐ 1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.
- ☐ 2 I have impulses to move about and am quite restless.
- ☐ 3 At times, I am unable to stay seated and need to pace around.