Adult Screening Form

Because we recognize that many issues in today's society are not openly discussed, Dr. Adeel Afzal is routinely asking our patients to answer the following questions. The purpose of asking these questions is to help us give you the best care possible. This questionnaire is entirely voluntary and you may choose not to complete the form.

I do <u>not</u> wish to complete this form. Please print name: _____ Date: _____

If your answer to any of the following questions is YES, please put a mark in this box ☐ Have you been feeling sad, "down" or depressed? Have you lost interest in things you used to enjoy? Has your appetite changed? Has your sleep changed? Have you had thoughts of dying or hurting yourself in some way?	***If your answer to any of the following questions is YES, please put a mark in this box*** ☐ Do you think you're at risk for HIV, AIDS, or other Sexually Transmitted Diseases? Have you ever had a blood transfusion? Do you ever have sex without using a condom? Have you had a Sexually Transmitted Disease such as syphilis, gonorrhea, or chlamydia? Have you had sex with more than one partner within the past year? Have you ever used needles to inject drugs (other than insulin or drugs ordered by your clinician)? (This question is for <u>women</u> only.) Has it been longer than three years since the last time you had a Pap Test or have you ever been told that you had an abnormal Pap Test?
If your answer to any of the following questions is YES, please put a mark in this box ☐ Do you often get tired easily? Do you often feel irritable? Do you often have problems falling or staying asleep?	
If your answer to any of the following questions is YES, please put a mark in this box ☐ Have you ever thought about cutting down on your alcohol or drug use? Have you ever become angry when other criticized your alcohol or drug use? Have you ever felt guilty about your drug or alcohol use? Have you ever used alcohol or drugs as an "eye opener" first thing upon waking? Has your drinking or drug use ever affected your relationships with your family, work, or school?	***If your answer to any of the following questions is YES, please put a mark in this box*** ☐ In the past year, have you been threatened, or felt controlled by your spouse, partner, or caretaker? Have you or your partner, spouse, or caretaker ever used physical force when you were arguing? Has your partner, spouse, or caretaker ever destroyed things that you care about? Are you ever afraid of your spouse, partner, or caretaker?

Please help us understand how much pain you experience by answering the following questions:

1. Do you experience pain or suffering? Never ☐ Some of the time ☐ Most of the time ☐ All of the time ☐
2. Are you currently taking medication(s) or using some type of treatment for pain relief? ☐ Yes ☐ No
3. How would you rate the <u>severity</u> of your pain? ***Circle*** the words below that best reflect your current level of pain.

   No Pain Hurts a little bit Hurts a little more Hurts a whole lot Hurts really bad

4. Do you want your doctor to talk with you about your pain? ☐ Yes ☐ No

****

☐ No intervention required ☐ Intervention recommended. ***See progress note.***

Clinician Signature: _____ Date: _____