Last Name: _________________ **First Name:** _______________ **Last Four:** __________________

This is a standard set of questions about several areas of your life such as your mood, health, alcohol, and drug use, etc. Please considered each question and answer as accurately as possible. This is completely ***VOLUNTARY.*** *Anything that you report is confidential and will not affect your care.*

Over the **LAST 2 WEEKS**, how often have you been bothered by any of the following problems	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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 usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

If you experienced any of the above 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 at all difficult	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

Over the **LAST 2 WEEKS**, how often have you been bothered by any of the following problems	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or to control worry	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something bad may happen	☐	☐	☐	☐

1. Do you ever hear, see, or feel things that are not there, for example, hear voices, noises, or sounds, see objects, people, or animals, or feel strange sensations inside your body or on your skin?
   ☐ No ☐ Yes
2. Do you have any beliefs that someone is following you, watching you, or trying to harm or control you, or that others can hear your thoughts or that you can hear their thoughts, or that you have special powers or special importance?
   ☐ No ☐ Yes
3. Have there been times lasting at least a few days when your mood was unusually "up" or unusually irritable, and you felt "on top of the world," or you were more active or talkative than usual, or you don't feel the need for sleep?
   ☐ No ☐ Yes

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1. How often did you have a drink containing alcohol in the **PAST YEAR**? Consider a drink a bottle of beer, a glass of wine, a wine cooler, or one cocktail or a shot of hard liquor (like scotch, gin, or vodka)

Never	Monthly or less	2-4 times a month	2-3 times per week	4 or more times a week
☐	☐	☐	☐	☐

2. How many drinks did you have on a typical day when you were drinking in the **PAST YEAR**?

0 drinks	1-2 drinks	3-4 drinks	5-6 drinks	7-9 drinks	10+ drinks
☐	☐	☐	☐	☐	☐

3. How often did you have 6 or more drinks (4 or more for women) on one occasion in the **PAST YEAR**?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
☐	☐	☐	☐	☐

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: a serious accident or fire, a physical or sexual assault or abuse, earthquakes or flood, war, seeing someone be killed or seriously injured, having a loved one die through homicide or suicide.

Have you ever experienced this kind of event? ☐ No ☐ Yes
If **NO**, please **STOP** here.

If **YES**, please answer the questions below:
In the **PAST MONTH**, have you:
1. Had any nightmares about the event(s) or thought about the event(s) when you did not want to?
   ☐ No ☐ Yes
2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
   ☐ No ☐ Yes
3. Were constantly on guard, watchful, or easily startled?
   ☐ No ☐ Yes
4. Felt numb or detached from others, activities, or your surroundings?
   ☐ No ☐ Yes
5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
   ☐ No ☐ Yes