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 _____

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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.

CAGE Questionnaire

Circle Yes or No to the questions below:

Have you ever felt you should **C**ut down on your drinking? YES NO

Have people **A**nnoyed you by criticizing your drinking? YES NO

Have you ever felt bad or **G**uilty about your drinking? YES NO

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)? YES NO

Scoring:
Item responses on the CAGE are scored 0 (No) or 1 (Yes), with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

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Developed by Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Cahpel Hill, CAGE is an internationally used assessment instrument
for identifying alcoholics.

Western Mental Health Center

Problem Checklist – Adult

Name: _____ Date: _____

In an effort to be helpful to you, it is important that we get a good idea about the things that are happening in your life. Mark a ***P = true in the past and C = for currently true*** (leave blank if neither apply)

__depressed mood
__decreased appetite
__difficulty falling or staying asleep
__fatigue or low energy level
__low self-esteem
__difficulty concentrating/making decisions
__feelings of hopelessness

__depressed mood nearly every day for 2 weeks
__loss of interest or pleasure nearly every day for 2 weeks
__decreased appetite nearly every day for 2 weeks
__difficulty sleeping nearly every day for 2 weeks
__feeling slowed down nearly every day for 2 weeks
__fatigue or a loss of energy nearly every day for 2 weeks
__feeling guilty or worthless nearly every day for 2 weeks
__difficulty concentrating nearly every day for 2 weeks
__recurrent thoughts of death or dying
__reduced sexual interest

__feeling "on top of the world" without any special reason
__decreased need for sleep
__being more talkative than usual (or pressure to keep talking)
__having racing thoughts or "flight ideas"
__ being easily distractible (by unimportant/irrelevant things)
__being hyperactive, agitated, or "speeded up"
__being impulsive (overspending, sexual sprees, or reckless driving)

__hearing a voice even when no one is around
__knowing special secrets which no one else believes
__having someone else read my mind or tamper with my thoughts
__having an outside force control my brain or thoughts
__using my own thought waves to control the thoughts of others

__feeling shaky or trembling
__muscle aches, soreness or tension
__restlessness or tension
__shortness of breath or smothering sensations
__palpitations or accelerated heart rate
__sweating or cold, clammy hands
__dry mouth
__dizziness or lightheadedness
__nausea, diarrhea, or other abdominal distress
__hot flashes or chills

__difficulty swallowing or a "lump in the throat"
__feeling "keyed up" or "on edge"
__exaggerated startle response (feeling jumpy)

__difficulty concentrating ("mind going blank") when nervous
__difficulty falling asleep or staying asleep
__irritability

__panic attacks with shortness of breath or smothering sensations
__panic attacks with dizziness or faintness
__panic attacks with palpitations or rapid heart rate
__panic attacks with trembling or shaking
__panic attacks with sweating
__panic attacks with choking
__panic attacks with nausea or abdominal distress
__panic attacks with feelings of unreality
__panic attacks with hot flashes or chills
__panic attacks with chest pain or discomfort
__panic attacks with a fear of dying
__panic attacks with a fear of "going crazy" or losing control

__vomiting (other than during pregnancy)
__pain in extremities
__shortness of breath
__amnesia
__difficulty swallowing
__burning sensation in sexual organs (other than during sex)
__painful menstruation
__loss of voice
__fainting or loss of consciousness
__blurred or double vision
__seizure or convulsion
__deafness
__abdominal pain (other than when menstruating)
__nausea (other than motion sickness)
__diarrhea
__back pain
__dizziness
__impotence
__headaches

__recurrent episodes of binge eating
__feeling a lack of control during episodes of binge eating
__self-induced vomiting, dieting or laxatives to prevent weight gain

__an average of two eating binges a week for at least 3 months
__persistent concern with body shape or weight
__significant weight loss during past year
__intense fear of gaining weight or becoming fat
__"feeling fat" regardless of actual body weight
__missing at least 3 consecutive menstrual periods
__drinking alcohol in larger amounts or longer than intended
__unsuccessfully trying to cut down or control drinking
__spending a lot of time drinking or recovering from being drunk
__drinking at times when I should have been doing other things
__giving up social or recreational activities because of drinking
__drinking despite arguments from family or friends
__drinking larger amounts to get the same effect

__using a larger amount of a drug than intended
__unsuccessfully trying to cut down or control use of a drug
__spending time using a drug or recovering from drug use
__difficulty keeping relationships/friendships lasting
__losing control with anger
__job/occupational difficulties
__concerns about children
__legal problems

__using a drug when supposed to be working or driving
__giving up social or recreational events because of drug use

__remembering painful things that have happened in the past
__needing everything to be perfect
__having thoughts that repeat themselves over and over
__feeling need to repeat certain behaviors over and over
__being really upset about something that has happened in the past 6 months
__having sexual problems

__physical health problems
__constant pain

In your own words, describe the problems you are currently experiencing:

Following your receiving therapy/counseling, what would like to see change about your life and situation?

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. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
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 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	

CDC Prediabetes Screening Test

NATIONAL Diabetes PREVENTION PROGRAM

COULD YOU HAVE PREDIABETES?

Prediabetes means your blood glucose (sugar) is higher than normal, but not yet diabetes. Diabetes is a serious disease that can cause heart attack, stroke, blindness, kidney failure, or loss of feet or legs. Type 2 diabetes can be delayed or prevented in people with prediabetes through effective lifestyle programs. Take the first step. Find out your risk for prediabetes.

TAKE THE TEST—KNOW YOUR SCORE!

Answer these seven simple questions. For each "Yes" answer, add the number of points listed. All "No" answers are 0 points.

Yes	No	
1	0	Are you a woman who has had a baby weighing more than 9 pounds at birth?
1	0	Do you have a sister or brother with diabetes?
1	0	Do you have a parent with diabetes?
5	0	Find your height on the chart. Do you weigh as much as or more than the weight listed for your height?
5	0	Are you younger than 65 years of age and get little or no exercise in a typical day?
5	0	Are you between 45 and 64 years of age?
9	0	Are you 65 years of age or older?

Add your score and check the back of this page to see what it means.

AT-RISK WEIGHT CHART

Height	Weight *Pounds*	Height	Weight *Pounds*
4'10"	129	5'7"	172
4'11"	133	5'8"	177
5'0"	138	5'9"	182
5'1"	143	5'10"	188
5'2"	147	5'11"	193
5'3"	152	6'0"	199
5'4"	157	6'1"	204
5'5"	162	6'2"	210
5'6"	167	6'3"	216
		6'4"	221

National Center for Chronic Disease Prevention and Health Promotion
Division of Diabetes Translation

CLIENT#_____ PRIMARY CARE SCREENER

1. **Are you currently receiving Palliative (Pain management) care? Yes or No
2. **BMI Percentile (ages <20 years): _____%
3. Do you have a primary care provider? Yes or No
    a. Who? _____
    b. Last time seen: Date: _____
4. Do you have a history of asthma or shortness of breath? Yes or No
    a. Rating:
        i. Normal
        ii. Concerned
        iii. Panic Attack
    b. When was your last onset of shortness of breath?
        i. Date: _____
5. Are you over 50 and had a colonoscopy? Yes or No If yes, when: Date: _____
6. Are you over 40 and had a mammogram? Yes or No If yes, when: Date:_____
7. Do you have any medical concerns or symptoms:

Height: ___
Weight: ___

8. Do you have any chronic/ongoing medical problems:

9. **Are you currently pregnant? Yes or No
10. Are you currently using contraception? Yes or No
11. Blood pressure Guide
    a. If 140-90 and no factors give handout
    b. If 180-100 refer to primary care physician
    c. If 150/85 refer to primary care physician
    d. If 130/80 and have heart disease and diabetes refer to primary care physician

**QUESTIONS FOR CHILD PRIMARY CARE SCREENER