

Name & DOB: _____

Alcohol Misuse/Abuse (Audit C)

Use "x" or check to indicate your answer

Did you have a drink containing alcohol within the last year?

- Yes
- No

If 'Yes', how often did you have a drink containing alcohol in the last year?

- Never (0 points)
- Monthly or Less (1 points)
- 2 to 4 times a month (2 points)
- 2 to 3 times a week (3 points)
- 4 or more times a week (4 points)

If 'Yes', how many drinks did you have on a typical day when you were drinking in the past year?

- 1 or 2 drinks (0 points)
- 3 or 4 drinks (1 point)
- 5 or 6 drinks (2 points)
- 7 to 9 drinks (3 points)
- 10 or more drinks (4 points)

If 'Yes', how often did you have 6 or more drinks on one occasion in the past year?

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

Interpretation:

The AUDIT-c is scored on a scale of 0-12 (scores of 0 reflect no alcohol use).

In MEN, a score of 4 or more is considered positive

In WOMEN, a score of 3 or more is considered positive

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Generalized Anxiety Disorder 7 Item (GAD-7) Scale

Use "x" or check to indicate your answer

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
Feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being so restless that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you checked any problems, how difficult have they 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

Interpretation of total:

0-4 No Anxiety

5-9 Mild

10-14 Moderate

15+ Severe

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Opioid Risk Tool

Use "x" or check to indicate your answer

FAMILY HISTORY OF SUBSTANCE ABUSE

Check only those boxes that apply

	Yes	No
Family History of alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Family History of Illegal Drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Family History of drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>

PERSONAL HISTORY OF SUBSTANCE ABUSE

Check only those boxes that apply

	Yes	No
Personal history of alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Personal history of drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Personal history of prescription drugs abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Age between 16-45 years?	<input type="checkbox"/>	<input type="checkbox"/>
Personal history of pre-adolescent sexual abuse?	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHOLOGIC DISEASE

Check only those boxes that apply

	Yes	No
ADD, ODD, Bipolar, Schizophrenia?	<input type="checkbox"/>	<input type="checkbox"/>
Depression?	<input type="checkbox"/>	<input type="checkbox"/>

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PEG SCALE

Circle the answer(s) that apply

What number best describes your pain in the past week?

0 1 2 3 4 5 6 7 8 9 10

No Pain

Pain as bad
as you can
imagine

What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely
Interferes

What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely
Interferes

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Depression Screening PHQ2 (2015 edition)

Use "x" or check to indicate your answer

Little interest or pleasure doing things?

- Not at all
- Several days
- More than half the days
- Nearly every day
- Declined to Specify

Feeling down, depressed, or hopeless?

- Not at all
- Several days
- More than half the days
- Nearly every day
- Declined to Specify

Interpretation

0 = Declined to Specify

0 = Not at all

1 = Several Days

2 = More than half of the days

3 = Nearly every day

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Patient Health Questionnaire (PHQ-9)

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling asleep, staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself, or that you are a failure, or have let yourself or family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things such as reading the newspaper or watching television?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 more often than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead, or hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Interpretation of Total Score for Depression:

1-4 Minimal Depression

5-9 Mild Depression

10-14 Moderate Depression

15-19 Moderately Severe Depression

20-27 Severe Depression

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Tobacco Screening

Are you a

- Current smoker
- Former smoker
- Nonsmoker
- Current every day smoker
- Current some day smoker
- Smoker current status unknown
- Unknown if ever smoked
- Light tobacco smoker
- Heavy tobacco smoker
- Uses tobacco in other forms

If a current smoker, how often do you smoke cigarettes?

- Every day
- Some days, but not every day

If a current smoker, how many cigarettes a day do you smoke?

- 5 or less
- 6-10
- 11-20
- 21-30
- 31 or more

If a current smoker, how soon after you wake up do you smoke your first cigarette?

- within 5 minutes
- 6-30 minutes
- 31-60 minutes
- after 60 minutes

If current smoker, are you interested in quitting?

- Ready to quit
- Thinking about quitting
- Not ready to quit