BEHAVIORAL HEALTH SCREENING

Name:_____ **Date**:_____

Have you ever been treated for (check all that apply):

☐ Depression ☐ Bipolar Disorder ☐ Anxiety Disorder ☐ Post Traumatic Stress Disorder ☐ Alcohol Abuse ☐ Chronic Pain

☐ Diabetes ☐ Drug Abuse ☐ Eating Disorder ☐ HIV ☐ Thyroid Disorder ☐ Seizure Disorder ☐ None of the above

Did treatment include medication? ☐ Yes ☐ No **Have you ever attempted suicide**? ☐ Yes ☐ No

PHQ-9 Place an "X" in the box beneath the answer that best describes how you've been feeling in the ***PAST TWO WEEKS***.	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or over-eating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down.				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or, the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you'd be better off dead or of hurting yourself in some way?				
Score (add score from each column and total)				
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				
			TOTAL SCORE	

GAD-7 Place an "X" in the box beneath the answer that best describes how you've been feeling in the ***PAST TWO WEEKS***.	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling nervous, anxious, or on edge?				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful is might happen				
Score (add score from each column and total)				
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				
			TOTAL SCORE	

EATING Place an "X" in the box beneath the answer that best describes you.	Yes	No
1. Do you worry that you have lost control over how much you eat?		
2. Do you make yourself sick when you feel uncomfortably full?		
3. Do you currently suffer with or have you ever suffered in the past with an eating disorder?		
4. Do you ever eat in secret?		
TOTAL SCORE		

MDQ Place an "X" in the box beneath the answer that best describes you. ***1. Has there ever been a period of time where you were not your usual self and…***	Yes	No
…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?		
…you were so irritable that you shouted at people or started fights or arguments?		
…felt much more self-confident than usual?		
…got much less sleep than usual and found you didn't really miss it?		
…you were much more talkative or spoke much faster than usual?		
…thoughts raced through your head or you couldn't slow your mind down?		
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
…you had much more energy than usual?		
…you were much more active or did many more things than usual?		
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
…you were much more interested in sex than usual?		
…you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?		
…spending money got you or your family into trouble?		
Score (add score from each column and total)		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		
How much of a problem did any of these cause you (i.e. unable to work, family/money/legal trouble, arguments/fights)? ☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem		

PTSD-PC Place an "X" in the box beneath the answer that best describes you. In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the ***PAST MONTH***, you:	Yes	No
1. Have had nightmares about it or thought about it when you did not want to?		
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?		
3. Were constantly on guard, watchful, or easily startled?		
4. Felt numb or detached from others, activities, or your surroundings?		
5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?		
TOTAL SCORE		

AUDIT Circle the most appropriate response					
1. How often do you have a drink containing alcohol?	Never (0)	Monthly or less (1)	2-4 times/month (2)	2-3 times/week (3)	4 or more times/week (4)
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7,8, or 9 (3)	10 or more (4)
3. How often do you have 6 or more drinks on one occasion?	Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost daily (4)
				TOTAL SCORE (add total numbers)	

DAST – 10 Circle the response that best describes your involvement with drugs in the ***PAST YEAR***	Yes	No
1. Have you used drugs other than those required for medical reasons	1	0
2. Do you abuse more than one drug at a time?	1	0
3. Are you always able to stop using drugs when you want to?	0	1
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	1	0
5. Do you ever feel bad or guilty about your drug use?	1	0
6. Do your spouse or parents ever complain about your involvement with drugs?	1	0
7. Have you neglected your family because of your use of drugs?	1	0
8. Have you engaged in illegal activities in order to obtain drugs?	1	0
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	1	0
10. Have you had medical problems as a result of your drug use (i.e. memory loss, hepatitis, convulsions, bleeding)?	1	0
TOTAL SCORE (# of yes)		

SCREENING SCORING

PHQ-9

0-4	Minimal	No Action
5-9	Mild	Watchful Waiting, repeat PHQ9 at follow up
10-14	Moderate	Treatment plan, consider counseling, follow up and/or pharmacotherapy
15-19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20-27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

GAD-7

0-4	Minimal
5-9	Mild
10-14	Moderate
15-21	Severe

EATING (combination of SCOFF and ESP)

Answering **"yes" to two or more** of the questions indicates it is "quite likely" the respondent has an eating problem. Anyone scoring a two or higher should seek an evaluation by a qualified professional, preferably someone with a background in assessing eating concerns.

MDQ

Yes to 7 or more or more in Question 1 AND
Yes to Question 2 AND
Moderate or Severe problem indicated in Question 3

PTSD-PC

PC-PTSD should be considered "positive" if a patient answers **"yes" to any** four items.

AUDIT-C

- In Men, 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders
- In women, 3 ore more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders
- However if points are all from Question 1 (questions 2 and 3 are 0) it can be assumed that patient is drinking below recommended limits
- In general, the higher the score, the more likely it is that the patients drinking is effecting safety

DAST-10

0	None	Monitor
1-2	Low	Brief Counseling
3-5	Intermediate (likely meets DSM criteria)	Outpatient
6-8	Substantial	Intensive
9-10	Severe	Intensive