

Name \_\_\_\_\_ Medical Record No. \_\_\_\_\_ Date \_\_\_\_\_

*Please answer the questions below. The information you provide will remain confidential.*

Please circle a number on the scale following each item to show how much you are troubled now by each problem listed below.

1. Feeling miserable or depressed

1	2	3	4	5	6	7	8	9
Hardly		Slightly		Moderately		Noticeably		Very Severely

2. Feeling irritable or angry

1	2	3	4	5	6	7	8	9
Hardly		Slightly		Moderately		Noticeably		Very Severely

3. Feeling tense, anxious or panicky

1	2	3	4	5	6	7	8	9
Hardly		Slightly		Moderately		Noticeably		Very Severely

4. Feeling under stress or pressure at work or home

1	2	3	4	5	6	7	8	9
Hardly		Slightly		Moderately		Noticeably		Very Severely

Over the last two weeks, how often have you been bothered by either of the following problems (please circle your answer from the four choices listed)?

5. Little interest or pleasure in doing things

0	1	2	3
Not at all	Several Days	More than half the days	Nearly every day

6. Feeling down, depressed or hopeless

0	1	2	3
Not at all	Several Days	More than half the days	Nearly every day

(over)

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7. Would you like help with any of these areas?

Depression:     No                       Yes

Anxiety:         No                       Yes

Anger:           No                       Yes

Stress:          No                       Yes

8. Do you ever drink alcohol?

No (Go to #15)

Yes

9. Have you ever felt that you ought to cut down on your drinking?     No                       Yes

10. Have people ever annoyed you by criticizing your drinking?     No                       Yes

11. Have you ever felt bad or guilty about your drinking?     No                       Yes

12. Have you ever had a drink first thing in the morning (eye opener) to steady your nerves or get rid of a hangover?     No                       Yes

13. About how often do you drink some kind of alcoholic beverage?

1  Daily or almost every day

2  3 or 4 times a week

3  Once or twice a week

4  Once or twice a month

5  Less often than once a month

6  Never

14. How many of these alcoholic beverages do you drink during an average week?

\_\_\_\_\_ # of 12 oz. bottles or cans of beer, ale, etc.

\_\_\_\_\_ # of 4 oz. glasses of wine, sherry, port, etc.

\_\_\_\_\_ # of shots (a shot = 1.5 ounces) of vodka, rum, scotch, whiskey, bourbon, tequila or gin (including mixed drinks and cocktails)

\_\_\_\_\_ # of after dinner drinks, liqueurs

15. Do you live alone?

No

Yes

16. Who helps you at home? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Thank you for responding to these questions. This information will remain confidential.*