Generalized Anxiety Disorder (GAD-7) Scale

Patient Information	
Date of Service:	
Patient Name:	
Date of Birth:	
Sex:	

Questionnaire				
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle your answers)	**Not at all**	**Several days**	**More than half the days**	**Nearly Everyday**
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
	0	1	2	3
Please calculate totals for each column and combine for Total Score.				

I you checked off any of the above problems, how difficult have these problems made it for 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	

Patient Questionnaire (PHQ-9)

Patient Information				
Date of Service:				
Patient Name:				
Date of Birth:				
Sex:				
Questionnaire				
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle your answers)	**Not at all**	**Several days**	**More than half the days**	**Nearly Everyday**
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 asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having a little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling badly about yourself, or feeling 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 fidgety 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 in some way	0	1	2	3
Please calculate totals for each column and combine for Total Score.	0			

If you checked off any of the above problems, how difficult have these problems made it for 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	

Tobacco Control

Patient Name: _____ Date: _____

Are you a:

Current Smoker: Y or N If yes, are you a light or heavy tobacco smoker? _____

Former Smoker How long ago did you stop smoking: _____

Never a Smoker

If you are a current tobacco user, please circle all applicable:

Chain smoker	Chews fine cut tobacco	Chews loose leaf tobacco
Chews plug tobacco	Chews tobacco	Chews twist tobacco
Smokes 1-9 cigarettes/day	10-19 cigarettes/day	20-39 cigarettes/day
40+ cigarettes/day	Rolls cigarettes	Snuff user
Trivial smoker less than 1 a day	User of moist powdered tobacco	Pipe User

If you are a former tobacco user, please circle all applicable:

Current non-smoker	Ex-1-9 cigarettes/day	Intolerant ex-smoker
Ex-cigar smoker	Ex-10-19 cigarettes/day	Ex-pipe smoker
Ex-cigarette smoker	Ex-20-30 cigarettes/day	Ex-trivial smoker
Ex-cigarette smoker amount unknown	Ex-40+ cigarettes/day	Ex-user of moist powder

If you are a non- tobacco user, please circle all applicable:

Aggressive non-smoker	Non-smoker for religious reasons
Intolerant non-smoker	Non-smoker for personal reasons
Non-smoker for medical reasons	Tolerant non-smoker

ALCOHOL SCREENING

Provider: _____

Date: _____

Name: _____ **DOB:** _____

Have you had a drink containing alcohol in the past year?

_____ YES

_____ NO

How often have you had six 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)

If you drink, how many drinks do you have on a typical day when you are drinking?

_____ 1 or 2 (0 points)

_____ 3 or 4 (1 point)

_____ 5 or 6 (2 points)

_____ 7 or 8 (3 points)

_____ 10 or more (4 points)

How often have you had a drink containing alcohol in the past year?

_____ Never (0 points)

_____ Monthly or less (1 point)

_____ Two to four times a month (2 points)

_____ Two to three times per week (3 points)

_____ Four or more times a week (4 points)

Interpretation

_____ Positive

_____ Negative

Interpretation

The AUDIT-C is scored on a scale of 0-12 (score of 0 reflects 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.