ALCOHOL USE QUESTIONS (AUDIT)

Drinking alcohol can affect your health and your daily life. Please help us assist you by answering the questions below.

One drink equals:	 12 oz. beer	 5 oz. wine	 1.5 oz. liquor (one shot)

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

In the past 12 months...	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	O Never	O Monthly or less	O 2 to 4 times a month	O 2 to 3 times a week	O 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	O 1 or 2	O 3 or 4	O 5 or 6	O 7 to 9	O 10 or more
3. How often do you have 5 or more drinks on one occasion?	O Never	O Less than monthly	O Monthly	O Weekly	O 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?	O Never	O Less than monthly	O Monthly	O Weekly	O Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	O Never	O Less than monthly	O Monthly	O Weekly	O 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?	O Never	O Less than monthly	O Monthly	O Weekly	O Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	O Never	O Less than monthly	O Monthly	O Weekly	O 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?	O Never	O Less than monthly	O Monthly	O Weekly	O Daily or almost daily
9. Have you or someone else been injured because of your drinking?	O No		O Yes, but not in the last year		O 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?	O No		O Yes, but not in the last year		O Yes, during the last year
Add scores for each column, then add across this row.					
				TOTAL	

Date_____

DRUG USE QUESTIONS (DAST-10)

Using drugs can affect your health and your daily life. Please help us assist you by answering the questions below.

Drugs include marijuana, solvents like paint thinners, tranquilizers like Valium, barbiturates, cocaine, stimulants like speed, hallucinogens such as LSD, or narcotics like heroin. Drug use also includes using prescription or over-the-counter medications more than directed.

In the past 12 months...	**1**	**0**
1. Have you used drugs other than those required for medical reasons?	○ Yes	○ No
2. Do you abuse more than one drug at a time?	○ Yes	○ No
3. Are you unable to stop using drugs when you want to?	○ Yes	○ No
4. Have you ever had blackouts or flashbacks as a result of drug use?	○ Yes	○ No
5. Do you ever feel bad or guilty about your drug use?	○ Yes	○ No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	○ Yes	○ No
7. Have you neglected your family because of your use of drugs?	○ Yes	○ No
8. Have you engaged in illegal activities in order to obtain drugs?	○ Yes	○ No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	○ Yes	○ No
10. Have you had medical problems as a result of your drug use (such as: memory loss, hepatitis, convulsions, or bleeding)?	○ Yes	○ No
TOTAL		

Date_____

Guidelines for Interpretation of AUDIT Scores

Score	Risk Level	Suggested Action
0-6 (Female) 0-7 (Male)	Little or no risk	Feedback and alcohol education
7-15 (Female) 8-15 (Male)	Moderate level	Brief intervention
16-19	High level	Brief intervention plus brief therapy
20-40	Substantial level	Brief intervention plus referral to chemical dependency treatment

Guidelines for Interpretation of DAST-10 Scores

Score	Risk Level	Suggested Action
0	No problems reported	Encouragement and education
1-2	Moderate level	Brief intervention
3-5	High level	Brief intervention plus brief therapy
6-10	Substantial level	Brief intervention plus referral to chemical dependency treatment

wasbirt·pci PHQ-9 Depression Scale

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	○ 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 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

10. If you checked off any problems on this questionnaire so far, how difficult have these problems made if 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
○ 0	○ 1	○ 2	○ 3

GAD-7 Anxiety Scale

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. 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

8. If you checked off any problems on this questionnaire so far, how difficult have these problems made if 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
○ 0	○ 1	○ 2	○ 3

IF total PHQ-9 ≥ 10
OR
IF total GAD-7 ≥ 10

This could indicate a clinically significant problem and should trigger an initial clinical assessment and consideration for follow up, referral to mental health program or enrollment in the Mental Health Integration Program

NOTE: On the PHQ-9, if the patient responds to question 9 with any answer other than "not at all," a suicide risk assessment needs to be completed.