# Supplemental Screening

# PHQ9

<cqaimh.org/pdf/tool_phq9.pdf> & [cqaimh.org/pdf/tool\_phq2.pdf](http://www.cqaimh.org/pdf/tool_phq2.pdf)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Questions:** | **Circle the box with your answer:** | | | |
| **Over the last 2 weeks 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 | 0 | 1 | 2 | 3 |
| 10. If you checked off any problems above, how difficult have those problems 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 |

# GAD-7

medi-mouse.com/graphics/GAD7.pdf

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| --- | --- | --- | --- | --- |
| **Questions** | **Circle the box with your answer:** | | | |
| **Over the last 2 weeks 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 |
| 1. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 1. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 1. Trouble relaxing | 0 | 1 | 2 | 3 |
| 1. Being so restless it is hard to sit still | 0 | 1 | 2 | 3 |
| 1. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 1. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

# PC-PTSD\* *Optional*

Scoring: any affirmative answer is “significant”

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

# CAGE

[mdcalc.com/cage-questions-alcohol-use](https://www.mdcalc.com/cage-questions-alcohol-use)

|  |  |  |
| --- | --- | --- |
| **Questions** | **Circle:** | |
| 1. Have you ever felt you needed to **C**ut down on your drinking? | Yes | No |
| 2. Have people **A**nnoyed you by criticizing your drinking? | Yes | No |
| 3. Have you ever felt bad or **G**uilty about your drinking? | Yes | No |
| 4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)? | Yes | No |

# DAST-10

[emcdda.europa.eu/html.cfm/index3618EN.html](http://www.emcdda.europa.eu/html.cfm/index3618EN.html)

|  |  |  |
| --- | --- | --- |
| **In the last 12 months…** | **Circle:** | |
| 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 always able to stop using drugs when you want to? (If never use drugs, answer “Yes”.) | 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? (If never use drugs, choose “No”.) | 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 (e.g., memory loss, hepatitis, convulsions, bleeding)? | Yes | No |