

For ages 12 & up

## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? (Use “✓” to indicate your answer)

	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

If you checked off **any** problems, how **difficult** have these 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

☐

## **Screening to Brief Intervention (S2BI): For ages 12-17**

In the <b>PAST YEAR</b> , how many times have you used:	<b>Never</b>	<b>Once or twice</b>	<b>Monthly</b>	<b>Weekly</b>
Tobacco				
Alcohol				
Marijuana				
Prescription drugs that were not prescribed for you: (such as pain medication or Adderall)				
Illegal drugs: (such as cocaine or ecstasy)				
Inhalants: (such as nitrous oxide)				
Herbs or synthetic drugs: (such as salvia, "K2", or bath salts)				

## **Audit-C Questionnaire: For ages 18 & up**

1. How often do you have a drink containing alcohol?
  - ☐ Never
  - ☐ Monthly or Less
  - ☐ 2-4 times a month.
  - ☐ 2-3 times a week
  - ☐ 4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day?
  - ☐ 1 or 2
  - ☐ 3 or 4
  - ☐ 5 or 6
  - ☐ 7 to 9
  - ☐ 10 or more
3. How often do you have six or more drinks on one occasion?
  - ☐ Never
  - ☐ Less than monthly
  - ☐ Monthly
  - ☐ Weekly
  - ☐ Daily or almost daily

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Caregiver/Guardian Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**In order to help us better understand you/your child and meet your needs, please answer the questions below. Some of these questions might not apply to you/your child. In that case, please answer "No."**

What is your pain level on a scale of 0 (none) – 10 (worst)? \_\_\_\_\_ Location/Nature of Pain: \_\_\_\_\_

- Yes    ○ No    Have you had a full medical exam in the last year?  
When? \_\_\_\_\_ By whom? \_\_\_\_\_ Where \_\_\_\_\_
- Yes    ○ No    Do you have a Psychiatric Advanced Directive (PAD)? *A Psychiatric Advanced Directive is a legal document that allows another person to act on your behalf if you become acutely ill and unable to make decisions about treatment.*
- Yes    ○ No    Are there any legal documents that say who may make medical decisions for the patient? (ex: custody document, guardianship, etc.) If so, please provide a copy.
- Yes    ○ No    Do you have any of the concerns listed below:
  - Unintended weight change of 10 or more pounds in the last 3-6 months?
  - An illness or problem that made you change the kind and/or amount of food you eat?
  - Tooth or mouth problems that make it hard for you to eat?
  - A big change in desire to eat, or food intake, over the last 2 weeks?
  - Do you worry that you have lost control over how much you eat? Do you make yourself vomit when you feel uncomfortably full? Do you eat in secret?
- Yes    ○ No    Are you able to take care of yourself like you used to, or do things like you used to?
- Yes    ○ No    Are you having trouble with your finances? Are you unable to pay for the things you need?
- Yes    ○ No    Do you have constant, repeated difficulties with gambling that impact your quality of life?
- Yes    ○ No    Are you having trouble with your education?
- Yes    ○ No    Are you having trouble with work?
- Yes    ○ No    Are you having trouble reaching your goals because of legal problems?
- Yes    ○ No    Are there things about your cultural identity that impact your reasons for seeking help?  
Are there things about your cultural identity that are causing difficulties for you?
- Yes    ○ No    Are you sexually active?
- Yes    ○ No    Are you being forced to have sex?
- Yes    ○ No    Is anyone sexually threatening you or touching you in a way that makes you uncomfortable?
- Yes    ○ No    Is anyone physically threatening, hurting or bullying you?
- Yes    ○ No    Is anyone verbally or emotionally threatening you?
- Yes    ○ No    Is anyone keeping you from:
  - Talking to who you want to?
  - Going where you want to go?
  - Seeing who you want to see?
  - Having food, water, clothing or a place to stay?
  - Going to the doctor or having medicine?
  - Using your money?

Other comments: \_\_\_\_\_

## **Self-Assessment Questionnaire: For all ages**

*For each statement, please mark the answer that best fits your situation. If you are unsure about how to answer any of these statements, please speak to your provider for clarification. Some of these questions may not apply to you or your child, in that case please answer "No." If you are a parent answering for your child, please answer questions from your child's point of view.*

Historical Factors		
No	Yes	
		<b>Have you ever</b> had a family member or close friend try to kill themselves?
		<b>Have you ever</b> tried to kill yourself or hurt yourself on purpose?
		<b>Have you ever</b> had THOUGHTS of killing or hurting yourself on purpose?
		<b>Have you ever</b> acted without thinking or without self-control in a way that put yourself or others in danger?

Current Factors		
No	Yes	
		<b>In the past 6 months</b> have you tried to kill yourself or hurt yourself on purpose?
		<b>In the past 6 months</b> have you acted without thinking or without self-control in a way that put yourself or others in danger?
		<b>In the past 6 months</b> have you been violent or aggressive towards people or property?
		<b>In the past 6 months</b> have you had THOUGHTS of killing yourself or hurting yourself on purpose?
		Do you have <b>any current</b> plan(s) to kill or hurt yourself or others?
		Do you <b>currently</b> intend to harm or kill yourself?
		Have you <b>recently</b> written a suicide note or have you begun giving your important belongings away to others?
		Have you <b>recently</b> heard things that other people don't hear? Do they tell what to do?
		Are you <b>currently</b> losing hope or feel that you are helpless?
		Are you <b>currently</b> having trouble with sleeping?
		Do you <b>currently</b> feel guilty, bad about yourself, or ashamed of yourself?
		Do you <b>currently</b> have chronic, repeated, or constant pain?

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Situational Factors		
No	Yes	
		Do you feel sick when you don't use alcohol or drugs for a short period of time?
		Do you have a long-lasting, serious illness?
		Have you had a <b>recent</b> loss? (example: death of a loved one, loss of a job, divorce or separation)
		Have you had any other <b>recent</b> bad news?

Protective Factors		
No	Yes	
		Do you have support from family?
		Do you have support from your spouse/significant other?
		Are you in charge of caring for children or other family?
		Do your friends provide you support when needed?
		Do you have strong religious or spiritual beliefs that keep you safe from hurting yourself?
		Did you graduate high school or earned your GED?