PINELLAS COUNTY HEALTH PROGRAM

Behavioral Health Screening Form

Client Name_____ **Date**_____

Date of Birth_____ **SS#**_____

Client phone/contact number_____

Please answer the following questions to the best of your ability. <u>All answers will be kept private.</u>

I. PHQ-9 PATIENT HEALTH QUESTIONNAIRE

Over the last **2 weeks**, how often have you been bothered by any of the following problems? *Please circle your responses on the right.*		**Not at all**	**Several days**	**More than half the time**	**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 over eating	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 slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot	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, 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? *Please circle only one response.*

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

II. GAD-7 GENERAL ANXIETY QUESTIONNAIRE

Over the last **2 weeks**, how often have you been bothered by any of the following problems? *Please circle your responses on the right.*		**Not at all**	**Several days**	**More than half the time**	**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 is 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

III. MDQ – MOOD QUESTIONNAIRE

1. Has there ever been a period of time when you were not your usual self and…..

… you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	Yes	No
… you were so irritable that you shouted at people or started fights or arguments?	Yes	No
… you felt much more self-confident than usual?	Yes	No
… you got much less sleep than usual and found you didn't really miss it?	Yes	No
… you were much more talkative or spoke much faster than usual?	Yes	No
… thoughts raced through your head or you couldn't slow your mind down?	Yes	No
… you were so easily distracted by things around you that you had trouble concentrating or staying on track?	Yes	No
… you had much more energy than usual?	Yes	No
… you were much more active or did many more things than usual?	Yes	No
… you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	Yes	No
… you were much more interested in sex than usual?	Yes	No
… you did things that were usual for you or that other people might have thought were excessive, foolish or risky?	Yes	No
… spending money got you or your family into trouble?	Yes	No
2. If you checked **YES** to **more than one** of the above, have several of these ever happened during the same period of time?	Yes	No

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle only one response.*

No problem **Minor problem** **Moderate problem** **Serious problem**

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	Yes	No
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	Yes	No

IV. SSI-SA SUBSTANCE USE QUESTIONNAIRE

The questions that follow are about your use of alcohol and other drugs. Mark the response that best fits for you. Answer the questions in terms of your experience in the **past 6 months**.

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens, or inhalants)	Yes	No
2. Have you felt that you use too much alcohol or other drugs?	Yes	No
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?	Yes	No
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors or a drug treatment program)	Yes	No
5. Have you had any health problems? For example, have you…		
…had blackouts or other periods of memory loss?	Yes	No
…injured your head after drinking or using drugs?	Yes	No
…had convulsions, delirium tremens ("DTs")?	Yes	No
…had hepatitis or other liver problems?	Yes	No
…felt sick, shaky, or depressed when you stopped?	Yes	No
…felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?	Yes	No
…been injured after drinking of using?	Yes	No
…used needles to shoot drugs?	Yes	No
6. Has drinking or other drug use caused problems between you and your family or friends?	Yes	No
7. Has your drinking or other drug use caused problems at school or at work?	Yes	No
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession)	Yes	No
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?	Yes	No
10. Are you needing to drink or use drugs more and more to get the effect you want?	Yes	No
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?	Yes	No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?	Yes	No
13. Do you feel bad or guilty about your drinking or drug use?	Yes	No
14. Have you ever had a drinking or other drug problem?	Yes	No
15. Have any of your family members ever had a drinking or drug problem?	Yes	No
16. Do you feel that you have a drinking or drug problem now?	Yes	No