Staley Health Services
187-18 Linden Boulevard, ST Albans NY 11412. PH. (347) 894-8111,
Fax: (347) 894-8128

Name: Address:

1. What sort of problems do you have?

_____

_____

2. What sort of help and treatment do you want?

_____

3. How do your problems affect your life?_____

_____

4. Are you able to talk with your family and your relatives about your problem?

_____

S. Do you have a faith or belong to a religious community that is a support and help for you?

_____

6. What language do you speak?_____

7. What language do you prefer to use?_____

8. Do you identify with any ethnic group? (E.g., Hispanic, African American, West Indian, Guyanese, Irish etc)

_____

9. What about your culture is important for the therapist/provider to know?

_____

Patient Signature:_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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 figety 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
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

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?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

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General Anxiety Disorder (GAD-7)

NAME

DATE

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				
TOTAL SCORE *(add your column scores)*				

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, 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?	☐ 0	☐ 1	☐ 2	☐ 3

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke, et.al.

These questions refer to the past 12 months.

Circle your response

1. Have you used drugs other than those required for medical reasons? ..... Yes No
2. Have you abused prescription drugs? ..... Yes No
3. Do you abuse more than one drug at a time? ..... Yes No
4. Can you get through the week without using drugs? ..... Yes No
5. Are you always able to stop using drugs when you want to? ..... Yes No
6. Have you had "blackouts" or "flashbacks" as a result of drug use? ..... Yes No
7. Do you ever feel bad or guilty about your drug use? ..... Yes No
8. Does your spouse (or parents) ever complain about your involvement with drugs? ..... Yes No
9. Has drug abuse created problems between you and your spouse or your parents? ..... Yes No
10. Have you lost friends because of your use of drugs? ..... Yes No
11. Have you neglected your family because of your use of drugs? ..... Yes No
12. Have you been in trouble at work because of drug abuse? ..... Yes No
13. Have you lost a job because of drug abuse? ..... Yes No
14. Have you gotten into fights when under the influence of drugs? ..... Yes No
15. Have you engaged in illegal activities in order to obtain drugs? ..... Yes No
16. Have you been arrested for possession of illegal drugs? ..... Yes No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? ..... Yes No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? ..... Yes No
19. Have you gone to anyone for help for a drug problem? ..... Yes No
20. Have you been involved in a treatment program specifically related to drug use? ..... Yes No

Canadian Guideline for Safe and Effective Use of Opioids for CNCP — Part B

CAGE Questionnaire

"CAGE" is an acronym formed from the italicized words in the questionnaire (cut-annoyed-guilty-eye).

The CAGE is a simple screening questionnaire to id potential problems with alcohol.

Two "yes" responses is considered positive for males; one "yes" is considered positive for females.

Please note: This test will only be scored correctly if you answer each one of the questions.

Please check the one response to each item that best describes how you have felt and behaved over your whole life.

Have you ever felt you should cut down on your drinking?

__Yes
__No

Have people annoyed you by criticizing your drinking?

__Yes
__No

Have you ever felt bad or guilty about your drinking?

__Yes
__No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

__Yes
__No

Click CAGE for more details.

Substance Use Screening & Assessment Instruments Database
Alcohol And Drug Abuse Institute
University of Washington

DRUG USE QUESTIONNAIRE (DAST-20)

Name: _____ Date: _____

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

For information on the DAST, contact Dr. Harvey Skinner at the Addiction Research Foundation, 33 Russell St., Toronto, Canada, M5S 2S1.