

Patient Name: _____ MRN: _____ DOB: _____ Date of Visit: _____

Generalized Anxiety Disorder Screen (GAD-7)

| Over the <i>last 2 weeks</i>, how often have you been bothered by 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 is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritated | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| | Add columns | | | |
| | Total Score | | | |
| 8. 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 |

Please complete the checklist before seeing your doctor or nurse. Your responses will help you receive the best health care possible.

Please sign and date anywhere indicated.

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Providers name: _____

1. Have you fallen in the past year?
 - Yes No
2. Are you afraid of falling?
 - Yes No
 - Number of falls in the last year? _____
 - Has there been any injury from falls?
 - Yes No
3. How many number of servings per day do you usually have of:
 - Proteins: _____ -Grains: _____
 - Vegetables: _____ -Fruits: _____
 - Junk food: _____ -Soda: _____
 - Water: _____
4. Are you a smoker?
 - No
 - Quit Date: _____
 - Yes, and I might quit
 - Yes, but I'm not ready to quit
5. What is the date of your last exam?
 - Date of eye exam: _____ Dr. _____
 - Date of dental exam: _____ Dr. _____
6. Do you exercise for about 20 minutes three or more days a week?
 - Yes, most of the time
 - Yes, some of the time
 - No, I actually do not exercise this much
7. During the past four weeks, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?
 - Not at all
 - Slightly
 - Moderately
 - Quite a bit
 - Extremely
8. During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?
 - Not at all
 - Slightly
 - Moderately
 - Quite a bit
 - Extremely
9. During the past four weeks, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely, or blue; sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of you.)
 - Yes, as much as I wanted

- Yes, quite
- Yes, some
- Yes, a little
- No, not at all

10. How have things been going for you during the past four weeks?

- Very well; could hardly be better
- Pretty well
- Good and bad parts about equal
- Pretty bad
- Very bad; could hardly be worse

11. Have you ever been given any information to help you with the following:

Hazards in your house that might hurt you?

- Yes
- No

Keeping track of your medications?

- Yes
- No

12. In the past four weeks how well have you been able to perform the following activities?

| | | | |
|-----|-----|------|--|
| No | | | |
| hel | Hel | | |
| p | p | Un | |
| ne | ne | abl | |
| ed | ed | e to | |
| ed | ed | do | |

| | | | |
|--|--|--|--|
| Bathing | | | |
| Dressing | | | |
| Eating | | | |
| Toilet use | | | |
| Transferring in or out of chair or bed | | | |
| Shopping | | | |
| Housekeeping | | | |

13. How often do you have trouble taking medications the way you have been told to take them?

- I do not have to take medication
- I always take them as prescribed
- Sometimes I take them as prescribed
- I seldom take them as prescribed

14. Are you having difficulties driving your car?

- Yes, often
- Sometimes
- No
- Not applicable, I do not drive a car

15. Can you handle your own money without help?

- Yes
- No

16. Are you having difficulties remembering things?

- Yes, often
- Sometimes
- No

17. Do you have any of the following in your home:

- Electric cords across floor
- Poor lighting
- Throw rugs
- Slippery bath/shower
- Unstable chairs/furniture
- Unsafe steps
- Functioning smoke detectors
- Fire extinguishers
- Grab bars in bath
- Handrails on stairs

18. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?

- 10 or more drinks per week
- 6 – 9 drinks per week
- 2 – 5 drinks per week

- One drink or less per week
- No alcohol at all

19. How confident are you that you can control and manage most of your health problems?

- Very confident
- Somewhat confident
- Not very confident
- I do not have health problems

Patient Signature

Date

The CRAFFT Questionnaire (version 2.1)

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the **PAST 12 MONTHS**, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.

of days

2. Use any **marijuana** (weed, oil, or hash, by smoking, vaping, or in food) or "**synthetic marijuana**" (like "K2," "Spice") or "vaping" **THC oil**? Put "0" if none.

of days

3. Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none.

of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- If you put "0" in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.
- If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 4-9.

No Yes

4. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

5. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?

6. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?

7. Do you ever **FORGET** things you did while using alcohol or drugs?

8. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?

9. Have you ever gotten into **TROUBLE** while you were using alcohol or
drugs?



NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:

The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

Informant “Self” Interview Questionnaire:

Today’s Date: _____

This form may be completed by the patient them self, or by a family/friend or care giver.

Informant’s name: _____

Informant’s relationship to patient: _____

These six questions ask how the patient is compared to when she was well, say 5-10 years ago.

Compared to a few years ago:

- | | Yes | No | Don’t Know | N/A |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| • Does the patient have more trouble remembering things that have happened recently than she used to? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Does the patient have more trouble recalling conversations a few days later? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Is the patient less able to manage their money and financial affairs e.g. paying bills, budgeting)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Is the patient less able to manage their medications Independently? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Does the patient need more assistance with transportation (either private or public)? (If the patient has difficulties due only to physical problems, e.g. bad leg, tick ‘no’) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

To get a total score, add the number of items answered ‘no’, ‘don’t know, or N/A)

Total score (out of 6):

If the patient scores 0-3, cognitive impairment is indicated. Conduct standard investigations.



PATIENT HEALTH QUESTIONNAIRE - 9 (PHQ-9)

Patient Name: _____ Today's Date: _____

Date of Birth: _____

| Over the last 2 weeks, how often have you been bothered by any of the following problems? <i>(Use "X" to indicate your answer)</i> | 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

?

FOR OFFICE CODING:

0 + _____ + _____ + _____

Total Score: _____

Social Determinants of Health Assessment Tool

To help identify health-related social needs (e.g., food, housing, social isolation, insurance, interpersonal violence, emotional well-being, transportation) in your patients, use this assessment tool to create a social determinants action plan.

Connect your patients with local and state community-based organizations that support social needs by visiting the 211.org website.

FOOD

YES **NO**

| | | |
|---|--------------------------|--------------------------|
| 1. Within the past 12 months, did you worry your food would run out before you got money to buy more? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Within the past 12 months, did the food you bought not last and you didn't have money to get more? | <input type="checkbox"/> | <input type="checkbox"/> |

HOUSING/UTILITIES

| | | |
|--|--------------------------|--------------------------|
| 3. Do you have housing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you worry about losing your housing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Within the past 12 months, have you or your family members you live with been unable to get heat, electricity, water when it was really needed? | <input type="checkbox"/> | <input type="checkbox"/> |

TRANSPORTATION

| | | |
|--|--------------------------|--------------------------|
| 6. Within the past 12 months, has lack of transportation kept you from going to medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need (Food)? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

SAFETY

| | | |
|--|--------------------------|--------------------------|
| 7. Do you feel physically and emotionally safe where you currently live? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Within the past 12 months, have you been disgraced or emotionally abused in other ways by your partner or ex-partner? | <input type="checkbox"/> | <input type="checkbox"/> |

HELP NOW

| | | |
|--|--------------------------|--------------------------|
| 10. Do you have needs that are urgent? For example: I don't have food for today, I don't have a place to sleep tonight, I don't have a ride home or to work, I am afraid I will get hurt if I go home today. | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

Additional Information