Patient Name: _____DOB:_____Today's Date:_____

Depression Risk Screening

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than Half the Days	Nearly Every Day
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much.	☐	☐	☐	☐
d. Feeling tired or having little energy.	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
Total	_____ +	_____ +	_____ +	_____ = _____

	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 people?	☐	☐	☐	☐

Alcohol Risk Screening

	Yes	No
Do you Drink Alcohol?	☐	☐
If Yes, please complete the following:		
Have you ever felt you ought to cut down on your drinking?	☐	☐
Do you get annoyed at criticism of your drinking?	☐	☐
Do you feel guilty about your drinking?	☐	☐
Do you ever take an early morning drink (eye opener) to get the day started to eliminate the "shakes"?	☐	☐

Alcohol Abuse Risk: Yes or No