Date: _____ Patient Name_____ MRN_____

Over the past 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
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless?	0	1	2	3
Trouble falling/staying asleep or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself; or that you are a failure or have let yourself or your family down?	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
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
Thoughts that you would be better off dead or of hurting yourself in some way?	0	1	2	3
PHQ-9 TOTAL				

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	Somewhat Difficult	Very Difficult	Extremely Difficult

DAST

Over the past twelve months have you:	YES	NO
Have you used drugs other than those required for medical reasons?	Y	N
Do you abuse more than one drug at a time?	Y	N
Are you **unable** to stop using drugs **when you want to**?	Y	N
Have you had "blackouts" or "flashbacks" as a result of drug use?	Y	N
Do you ever feel bad or guilty about your drug use?	Y	N
Does your spouse or parents ever complain about your involvement with drugs?	Y	N
Have you neglected your family because of your use of drugs?	Y	N
Have you engaged in illegal activities in order to obtain drugs?	Y	N
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Y	N
Have you had *medical problems* as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)	Y	N

AUDIT

Questions	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times/month	2-3 times/week	4 or more/week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found that you were unable to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you felt guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured as the result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year