Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)

Patient Name: _____ **Date:** _____

During the past 6 months:

1. Have you used alcohol or other drugs? (such as wine, beer, hard liquor, pot, coke, heroin or other opiates, 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 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 treatment program) ... Yes No
5. Have you had any of the following?
   Put a check mark next to any problems you have experienced.
   - ○ Blackouts or other periods of memory loss?
   - ○ Injury to your head after drinking or using drugs?
   - ○ Convulsions or delirium tremens (DTs)?
   - ○ Hepatitis or other liver problems?
   - ○ Felt sick, shaky, or depressed when you stopped drinking or using drugs?
   - ○ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   - ○ Injury after drinking or using?
   - ○ Used needles to shoot drugs?

   Circle "yes" if at least one of the eight items above is checked ..... 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 drugs? ..... Yes No
10. Do you need 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

The next questions are about lifetime experiences.

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

The Mood Disorder Questionnaire

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

3 How much of a problem did any of these cause you - like being able to work; having family, money or legal troubles; getting into arguments or fights?

O No problem O Minor problem O Moderate problem O Serious problem

4 *Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	O	O
5 *Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	O	O

This instrument is designed for screening purposes only and is not to be used as a diagnostic tool.

*Derived from Hirschfeld RM. *Am J Psychiatry.* 2000:157(11):1873-1875.

Versión en español en el reverso

Beck Anxiety Self Rating Scale

Your name: _____

Date: _____

For each item, 1 through 21, check the severity, 0, 1, 2, or 3, which best describes your experience today or in recent weeks

1. Numbness and tingling
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

2. Feeling hot
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

3. Wobbliness in legs
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

4. Unable to relax
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

5. Fear of the worst happening
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

6. Dizzy or lightheaded
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

7. Heart pounding or racing
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

8. Unsteady
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

9. Terrified
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

10. Nervous
    - ☐0 Not at all
    - ☐1 Mildly – It did not bother me much
    - ☐2 Moderately – It was very unpleasant but I could stand it
    - ☐3 Severely – I could barely stand it

11. Feelings of choking
    - ☐0 Not at all
    - ☐1 Mildly – It did not bother me much
    - ☐2 Moderately – It was very unpleasant but I could stand it
    - ☐3 Severely – I could barely stand it

12. Hands Trembling
    - ☐0 Not at all
    - ☐1 Mildly – It did not bother me much
    - ☐2 Moderately – It was very unpleasant but I could stand it
    - ☐3 Severely – I could barely stand it

13. Shaky
    - ☐0 Not at all
    - ☐1 Mildly – It did not bother me much
    - ☐2 Moderately – It was very unpleasant but I could stand it
    - ☐3 Severely – I could barely stand it

14. Fear of losing control
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

15. Difficulty breathing
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

16. Fear of dying
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

17. Scared
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

18. Indigestion or discomfort in abdomen
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

19. Faint
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

20. Face flushed
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

21. Sweating (not due to heat)
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

Scoring Instructions:

0 – 7	MINIMAL level of anxiety symptoms reported
0 – 15	MILD level of anxiety symptoms reported
16 – 25	MODERATE level of anxiety symptoms reported
26 – 63	SEVERE level of anxiety symptoms reported

A high score does not necessarily indicate that a person has an anxiety disorder, but indicates that a more detailed and individualized evaluation should be performed.

NAME:_____DATE:_____

BECK DEPRESSION INVENTORY

Please circle the number next to the sentence which best describes your symptoms. Choose only one sentence under each letter.

A.	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad or unhappy that I can't stand it.
B.	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel that the future is hopeless and things cannot improve.
C.	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failure.
	3	I feel I am a complete failure as a person.
D.	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.
E.	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
F.	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.
G.	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
H.	0	I don't feel I am any worse than anybody else.
	1	I am critical of myself for my weaknesses or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.
I.	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.
J.	0	I don't cry anymore than usual.
	1	I cry more now than I used to.
	2	I cry all the time now.
	3	I used to be able to cry, but now I can't cry even though I want to.

Self-Report Scale (ASRS) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below based on how you are currently doing on your medications.

	Never	Rarely	Sometimes	Often	Very Often	Score
1. How often do you make careless mistakes when you have to work on a boring or difficult project?	0	1	2	3	4	
2. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	0	1	2	3	4	
3. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	0	1	2	3	4	
4. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	0	1	2	3	4	
5. How often do you have difficulty getting things in order when you have to do a task that requires organization?	0	1	2	3	4	
6. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	0	1	2	3	4	
7. How often do you misplace or have difficulty finding things at home or at work?	0	1	2	3	4	
8. How often are you distracted by activity or noise around you?	0	1	2	3	4	
9. How often do you have problems remembering appointments or obligations?	0	1	2	3	4	
					Part A – Total	
10. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	0	1	2	3	4	
11. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	0	1	2	3	4	
12. How often do you feel restless or fidgety?	0	1	2	3	4	
13. How often do you have difficulty unwinding and relaxing when you have time to yourself?	0	1	2	3	4	
14. How often do you feel overly active and compelled to do things, like you were driven by a motor?	0	1	2	3	4	
15. How often do you find yourself talking too much when you are in social situations?	0	1	2	3	4	
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	0	1	2	3	4	
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	0	1	2	3	4	
18. How often do you interrupt others when they are busy?	0	1	2	3	4	
					Part B – Total	

PLEASANT CARE BEHAVIORAL HEALTH

Initial Psychiatric Assessment

THIS SECTION TO BE COMPLETE BY PATIENT OR PARENT (IF PATIENT IS A MINOR)

_____ _____ _____/_____/_____
PATIENT NAME (PRINT) **AGE** **TODAY'S DATE**

_____ _____
PERSON COMPLETING THIS FORM (PRINT) **RELATIONSHIP TO PATIENT**

_____
THERAPIST OR COUNSELOR'S NAME, ADDRESS, PHONE NUMBER

_____
PRIMARY CARE PROVIDER'S NAME, ADDRESS, PHONE NUMBER

REASON FOR EVALUATION: (IF PRESENT, RATE 0-10. 0 IS ABSENT, 10 IS EXTREME)
____ANXIETY____PANIC____DEPRESSION____MOOD SWINGS____SUICIDAL THOUGHTS
____SUICIDE ATTEMPT____AGITATION____AGGRESSION/VIOLENCE
____BEHAVIORAL PROBLEM____IMPULSIVITY____SCHOOL PROBLEMS
____RELATIONSHIP PROBLEMS____BIZZARE THOUGHTS____CONCENTRATION/FOCUS
____TASK COMPLETION____UNUSUAL OR STRANGE BEHAVIOR
____SLEEP PROBLEM____DRUG/ALCOHOL

BRIEFLY DESCRIBE PROBLEM:_____

_____

_____

_____

_____

PREVIOUS TREATMENT? ____THERAPY? WITH WHOM?_____

EVER HOSPITALIZED? ____ HOW MANY TIMES? ____ WHEN? _____

WHERE? _____

ON MEDICATION NOW? (NAME, DOSAGE, HOW LONG TAKEN, RESPONSE?)

_____

_____

_____

HERBALS OR SUPPLEMENTS? _____

MEDICATIONS USED IN THE PAST? ____Y ____N
NAME OF MEDICATION(S, DOSAGE(S, RESPONSE TO EACH_____

_____

MEDICATION ALLERGIES? _____

ANY MEDICAL PROBLEMS? _____

PLEASANT CARE BEHAVIORAL HEALTH

_____

HEIGHT _____ FT. _____ IN. WEIGHT _____ LBS.

DO YOU HAVE EXCESSIVE THIRST?____EXCESSIVE URINATION? ____

SUBSTANCE USE? (LIST ANY SUBSTANCES USED, PAST OR PRESENT, LAST USE

_____

_____

_____

FAMILY HISTORY: (ANY BLOOD RELATIVES YOU BELIEVE HAVE HAD SYMPTOMS OF A PSYCHIATRIC OR SUBSTANCE ABUSE PROBLEM

_____

_____

_____

_____

_____

LIVING SITUATION: (WHO LIVES AT HOME? _____

_____

_____

EDUCATION LEVEL:
CURRENT GRADE LEVEL (MINORS) _____

ACADEMIC PERFORMANCE ____ BELOW AVERAGE ____ AVERAGE ____ ABOVE AVERAGE

EDUCATION COMPLETED (ADULTS):

____ HIGH SCHOOL ____ GED ____ HOURS COLLEGE
____ COLLEGE GRADUATE ____ POST GRADUATE DEGREE

EMPLOYMENT _____