Adult Bi-Annual Questionnaire (18 years and older)

Twice a year, all of our patients are asked to complete this form because these factors can affect your health as well as the medications you may take. Please help us provide you with the best medical care by answering the questions below. **All information is confidential and cannot be used for legal purposes.**

Patient Name Label

Today's Date:_____

Over the last 2 weeks, how often have you been bothered by the following problems?	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
PHQ-2 Score [Total score for Questions 1-2]				

IF YOUR TOTAL SCORE IS 3 OR MORE, PLEASE ANSWER THE FOLLOWING QUESTIONS:
IF YOUR SCORE WAS 2 OR LESS, PLEASE TURN THE PAGE OVER AND COMPLETE THE BACK OF THIS FORM.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
3. Trouble falling asleep, 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're 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
10. If you checked off any problems, how difficult have those 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		Very difficult	
	Somewhat difficult		Extremely difficult	
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Total score for Questions 3-9				
PHQ-9 Score [Total of all questions 1-9]				

Please turn over and complete the questions on the back of this form.

1. Alcohol Use	One standard drink is equivalent to 12 ounces of beer, 5 ounces of wine, 1.5 ounces of liquor.				
These questions refer to the past 12 months	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
******IF YOU ANSWERED "NEVER" ABOVE AND YOU DO NOT DRINK, SKIP TO PART 2 BELOW******					
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2	3 or 4	5 or 6	7-9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily
5. 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
6. 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
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
					Total:

2. Recreational Drugs: *Recreational drugs include methamphetamines (speed, crystal) Cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).*

These questions refer to the past 12 months	**0**	**1**
1. Have you used drugs other than those required for medical reasons?	No	Yes
STOP HERE IF YOU HAVE NOT USED RECREATIONAL DRUGS IN THE LAST 12 MONTHS		
2. Have you abused prescription drugs?	No	Yes
3. Do you abuse more than one drug at a time?	No	Yes
4. Can you get through the week without using drugs?	No	Yes
5. Are you always able to stop using drugs when you want to?	No	Yes
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	No	Yes
7. Do you ever feel bad or guilty about your drug use?	No	Yes
8. Does your partner (or parents) ever complain about your involvement with drugs?	No	Yes
9. Has drug abuse created problems between you and your partner or parents?	No	Yes
10. Have you lost friends because of your use of drugs?	No	Yes
11. Have you neglected your family because of your use of drugs?	No	Yes
12. Have you been in trouble at work because of your use of drugs?	No	Yes
13. Have you lost a job because of drug abuse?	No	Yes
14. Have you gotten into fights when under the influence of drugs?	No	Yes
15. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
16. Have you been arrested for possession of illegal drugs?	No	Yes
17. Have you ever experience withdraw symptoms (felt sick) when you stopped taking drugs?	No	Yes
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	No	Yes
19. Have you gone to anyone for help for a drug problem?	No	Yes
20. Have you been involved in treatment program especially related to drug use?	No	Yes
	Total:	

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Medical Provider:_____ BHI:_____