

Wetzel-Rasmussen
Counseling Services

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Elcho, WI 54428

Name: _____

Date: _____

Cage Questionnaire

1. Have you ever felt you should **Cut** down on your drinking?
2. Have people **Annoyed** you by criticizing your drinking?
3. Have you ever felt bad or **Guilty** about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? (Eye opener)

Scoring: Item responses on the **CAGE** are scored 0 for "no" and 1 for "yes" answers, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

While the normal cut-off for the **CAGE** is 2 positive answers, the consensus panel of the substance abuse and mental health services administration recommends that primary care physicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders.

CAGE questions adapted to include drugs (**CAGE-AID**)

1. Have you ever felt you should **Cut** down on your drinking or drug use?
2. Have people **Annoyed** you by criticizing your drinking or drug use?
3. Have you ever felt bad or **Guilty** about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? (Eye opener)

Substance Abuse Screening Instrument	Yes	No
Have you ever done something crazy while high and had to make excuses for your behavior?		
Have you ever felt really burnt out for a day after using drugs?		
Have you ever gotten out of bed in the morning and felt really wasted?		
Did you ever get high in school?		
Have you gotten into a fight while you were high (including drinking)?		
Do you think about getting high a lot of the time?		
Have you ever thought about committing suicide when you were high?		
Have you ever run away from home, partly because of an argument over drug use?		
Did you ever try to stick to one drug after a bad experience mixing drugs?		
Have you gotten into a physical fight during a family argument over drug use?		
Have you ever been suspended because of something you did while high?		
Do you usually keep a supply (of drugs) for emergencies, no matter how small?		
Have you ever smoked some pot to get over a hangover?		
Have you ever felt nervous or cranky after you stopped using for a while?		
Score		

Brief Patient Health Questionnaire™ (PHQ-Brief)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

Name _____ Age _____ Sex: Female Male Today's Date _____

- | 1. Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems? | Not at all | Sever
al
days | More
than
half
the
days | Nearl
y
every
day |
|---|--------------------------|--------------------------|-------------------------------------|----------------------------|
| a. Little interest or pleasure in doing things | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Feeling down, depressed, or hopeless | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Trouble falling or staying asleep, or sleeping too much | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Feeling tired or having little energy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Poor appetite or overeating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Trouble concentrating on things, such as reading the newspaper or watching television | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Thoughts that you would be better off dead, or of hurting yourself in some way | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. Questions about anxiety.

- | | | |
|--|---------------------------------------|--|
| a. In the <u>last 4 weeks</u> , have you had an anxiety attack — suddenly feeling fear or panic? | NO
<input type="checkbox"/> | YES
<input type="checkbox"/> |
|--|---------------------------------------|--|

If you checked "NO", go to question #3.

- | | | |
|--|--------------------------|--------------------------|
| b. Has this ever happened before? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do some of these attacks come <u>suddenly out of the blue</u> — that is, in situations where you don't expect to be nervous or uncomfortable? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do these attacks bother you a lot or are you worried about having another attack? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach? | <input type="checkbox"/> | <input type="checkbox"/> |

3. If you checked off any problems 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 other people?

- | | | | |
|---|---|---|--|
| Not difficult
at all
<input type="checkbox"/> | Somewhat
difficult
<input type="checkbox"/> | Very
difficult
<input type="checkbox"/> | Extremely
difficult
<input type="checkbox"/> |
|---|---|---|--|

FOR OFFICE CODING: Maj Dep Syn if answers to #1a or b and five or more of #1a-i are at least "More than half the days" (count #1i if present at all). Other Dep Syn if #1a or b and two, three, or four of #1a-i are at least "More than half the days" (count #1i if present at all). Pan Syn if all of #2a-e are "YES."

- | 4. In the <u>last 4 weeks</u> , how much have you been bothered by any of the following problems? | Not
bothered | Bothered
a little | Bothered
a lot |
|---|--------------------------|--------------------------|--------------------------|
| a. Worrying about your health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Your weight or how you look | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Little or no sexual desire or pleasure during sex | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The stress of taking care of children, parents, or other family members | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Stress at work outside of the home or at school | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Financial problems or worries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Having no one to turn to when you have a problem | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Something bad that happened <u>recently</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Thinking or dreaming about something terrible that happened to you <u>in the past</u> - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

5. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? NO YES

6. What is the most stressful thing in your life right now? _____

7. Are you taking any medicine for anxiety, depression or stress? NO YES

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth.

a. Which best describes your menstrual periods?

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Periods are unchanged | <input type="checkbox"/> No periods because pregnant or recently gave birth | <input type="checkbox"/> Periods have become irregular or changed in frequency, duration or amount | <input type="checkbox"/> No periods for at least a year | <input type="checkbox"/> Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive |
|--|---|--|---|---|

- | | NO
(or does not apply) | YES |
|--|---------------------------|--------------------------|
| a. During the week before your period starts, do you have a <u>serious</u> problem with your mood - like depression, anxiety, irritability, anger or mood swings | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If YES: Do these problems go away by the end of your period? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have you given birth within the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you had a miscarriage within the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Are you having difficulty getting pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

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PATIENT HEALTH QUESTIONNAIRE (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability

A. During the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered (0)	Bothered a little (1)	Bothered a lot (2)
1. Stomach pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pain in your arms, legs, or joints (knees, hips, etc.)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Menstrual cramps or other problems with your periods.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Pain or problems during sexual intercourse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Fainting spells.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Feeling your heart pound or race.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Constipation, loose bowels, or diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Nausea, gas, or indigestion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHQ-15 Score = +

B. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Feeling nervous anxiety or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless that it is hard to sit still.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GAD-7 Score = + +