Name:_____ Date:_____

PHQ-9

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
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling 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 are a failure or have let yourself or 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

Total _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of the things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

GAD-7

Over the last 2 weeks, have you felt bothered by any of these things?	Not at all	Several Days	More than half the days	Nearly Every day
1. Feeling nervous, anxious, or on edge?	0	1	2	3
2. Not being able to stop or control worrying?	0	1	2	3
3. Worrying too much about different things?	0	1	2	3
4. Trouble relaxing?	0	1	2	3
5. Being so restless that it is hard to sit still?	0	1	2	3
6. Becoming easily annoyed or irritable?	0	1	2	3
7. Feeling afraid as if something awful might happen?	0	1	2	3

Total _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of the things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

PTSD Checklist (PCL) - 5

Name:_______ Date:_____

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Total _____

AUDIT C

Name:_____ Date:_____

1: How often did you have a drink containing alcohol in the past year?	
Answer	
Never	0
Monthly or less	1
Two to four times a month	2
Two to three times a week	3
Four or more times a week	4
2: How many drinks did you have on a typical day when you were drinking in the past year?	
Answer	
None, I do not drink	0
1 or 2	0
3 or 4	1
5 or 6	2
7 to 9	3
10 or more	4
3: How often did you have six or more drinks on one occasion in the past year?	
Answer	
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

Total _____

Brief Addiction Monitor-Revised (BAM-R)

Name:_____ Date:_____

This is a standard set of questions about several areas of your life such as your health, alcohol and drug use, etc. *The questions generally ask about the past 30 days. Please consider each question and answer as accurately as possible.*

Method of Administration:
Clinician Interview **Self Report** **Phone**

1. In the past 30 days, how would you say your physical health has been?

☐ Excellent (0)
☐ Very Good (8)
☐ Good (15)
☐ Fair (22)
☐ Poor (30)

2. In the past 30 days, how many nights did you have trouble falling asleep or staying asleep? ___ ___

3. In the past 30 days, how many days have you felt depressed, anxious, angry or very upset throughout most of the day?

___ ___

4. In the past 30 days, how many days did you drink ANY alcohol?

___ ___ (If 00, *Skip* to #6)

5. In the past 30 days, how many days did you have at least 5 drinks (if you are a man) or at least 4 drinks (if you are a woman)? [One drink is considered one shot of hard liquor (1.5 oz.) or 12-ounce can/bottle of beer or 5-ounce glass of wine.]

___ ___

6. In the past 30 days, how many days did you use any illegal or street drugs or abuse any prescription medications?

___ ___ (If 00, *Skip* to #8)

7. In the past 30 days, how many days did you use any of the following drugs:

7A. Marijuana (cannabis, pot, weed)?

___ ___

7B. Sedatives and/or Tranquilizers (benzos, Valium, Xanax, Ativan, Ambien, barbs, Phenobarbital, downers, etc.)?

___ ___

7C. Cocaine and/or Crack?

___ ___

7D. Other Stimulants (amphetamine, methamphetamine, Dexedrine, Ritalin, Adderall, speed, crystal meth, ice, etc.)?

___ ___

7E. Opiates (Heroin, Morphine, Dilaudid, Demerol, Oxycontin, oxy, codeine (Tylenol 2,3,4), Percocet, Vicodin, Fentanyl, etc.)?

___ ___

7F. Inhalants (glues, adhesives, nail polish remover, paint thinner, etc.)?

___ ___

7G. Other drugs (steroids, non-prescription sleep and diet pills, Benadryl, Ephedra, other over-the-counter or unknown medications)?

___ ___

8. In the past 30 days, how much were you bothered by cravings or urges to drink alcohol or use drugs?

☐ Not at all (0)
☐ Slightly (8)
☐ Moderately (15)
☐ Considerably (22)
☐ Extremely (30)

9. How confident are you that you will NOT use alcohol and drugs in the next 30 days?

☐ Not at all (0)
☐ Slightly (8)
☐ Moderately (15)
☐ Considerably (22)
☐ Extremely (30)

10. In the past 30 days, how many days did you attend self-help meetings like AA or NA to support your recovery?

___ ___

11. In the past 30 days, how many days were you in any situations or with any people that might put you at an increased risk for using alcohol or drugs (i.e., around risky “people, places or things”)?

___ ___

12. Does your religion or spirituality help support your recovery?

☐ Not at all (0)
☐ Slightly (8)
☐ Moderately (15)
☐ Considerably (22)
☐ Extremely (30)

13. In the past 30 days, how many days did you spend much of the time at work, school, or doing volunteer work?

___ ___

14. Do you have enough income (from legal sources) to pay for necessities such as housing, transportation, food and clothing for yourself and your dependents?

○ No (0)
○ Yes (30)

15. In the past 30 days, how much have you been bothered by arguments or problems getting along with any family members or friends?

☐ Not at all (0)
☐ Slightly (8)
☐ Moderately (15)
☐ Considerably (22)
☐ Extremely (30)

16. In the past 30 days, how many days did you contact or spend time with any family members or friends who are supportive of your recovery?

___ ___

17. How satisfied are you with your progress toward achieving your recovery goals?

☐ Not at all (0)
☐ Slightly (8)
☐ Moderately (15)
☐ Considerably (22)
☐ Extremely (30)