CareMEDICA Annual Screening

Insurance companies require providers to screen all patients for Depression, Alcohol use, and Tobacco use*

Patient Name: _____ D.O.B: _____

Patient Signature:_____ Date: _____

DEPRESSION SCREENING	**CHECK ALL THAT APPLY**				
Over the last 2 weeks, how often have you been bothered by any of the below:	**NOT AT ALL**	**SEVERAL DAYS**	**MORE THAN HALF THE DAYS**	**NEARLY EVERY DAY**	**REFUSE TO DISCLOSE**
1. Little interest or pleasure in doing things					
2. Feeling down, depressed, hopeless					
3. Trouble falling or staying asleep or sleeping too much					
4. Feeling tired or having little energy					
5. Poor appetite or overeating					
6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down					
7. Trouble concentrating on things, such as reading the newspaper or watching television					
8. Moving or speaking so slowly that other people could have noticed or being so fidgety that you have been moving around a lot more than usual					
9. Thoughts that you would be better off dead or hurting yourself in some way					
ALCOHOL SCREENING					
1. Have you had an alcoholic drink in the past year?	NO	YES *(If yes, please answer questions 2-4)*			
2. How often did you have a drink containing alcohol in the past year?	Never	Monthly	2-3 per month	2-3 per week	4 or more per week
3. How many drinks do you have on a typical day when you drink?	1-2	3-4	5-6	7-9	10 or more
4. How often did you have 6 or more drinks on one occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily

TOBACCO SCREENING		
1. Have you ever smoked tobacco/vaped?	NO	YES (If yes, please answer questions 2-4)
2. If you are a <u>former</u> smoker, how long ago did you stop?	_____	
3. If you are a <u>current</u> smoker, do you smoke or vape?	SMOKE	VAPE
4. If you are a <u>current</u> smoker, how heavy or light do you smoke/vape?	HEAVY	LIGHT

ANXIETY SCREENING	Rate how often you've been bothered by the following problems over the past two weeks (0 = Not at all to 3 = Nearly every day):			
1. Feeling nervous, anxious, or on edge	**NOT AT ALL**	**SEVERAL DAYS**	**MORE THAN HALF THE DAYS**	**NEARLY EVERY DAY**
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's 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