CareMEDICA Annual Screening

Please complete each section. Select one response per question.

Patient name: _____ **Date of birth:** _____ **Date:** _____

Depression screening PHQ-9

Over the last two weeks, how often have you been bothered by the following?	Not at all	Several days	More than half the days	Nearly every day	Prefer not to answer
1. Little interest or pleasure in doing things	☐	☐	☐	☐	☐
2. Feeling down, depressed, or 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 or restless 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 AUDIT-C

1. Have you had an alcoholic drink in the past year?	☐ No			☐ Yes - 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 or vaped?	☐ No	☐ Yes - answer questions 2-4
2. If you are a former smoker, how long ago did you stop?	_____	
3. If you are a current smoker, do you smoke or vape?	☐ Smoke	☐ Vape
4. If you are a current smoker, how heavy or light do you smoke/vape?	☐ Heavy	☐ Light

Anxiety screening GAD-7

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

Patient signature: _____ **Date:** _____ **Provider initials:** _____