Patient Name: _____ Date: _____

GAD-7 **Over the last 2 weeks, how often have you been bothered by any of the following problems?** (Circle to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**	**Row Total**
1. Feeling nervous, anxious, on edge	0	1	2	3	
2. Not being able to stop or to 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 Score

PHQ-9 **Over the last 2 weeks, how often have you been bothered by any of the following problems?** (Circle to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**	**Row Total**
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 or 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 are 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	
					Total Score

Name: _____ Date:_____

AUDIT-C **Please answer the following three questions.** (Circle to indicate your answer)	**0**	**1**	**2**	**3**	**4**
1. How often did 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
2. How many drinks containing alcohol did you have on a typical day when you were drinking?	1 or 2	3 or 5	5 or 6	7 to 9	10 or more
3. How often did you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Functioning **If you checked any problems on this questionnaire, 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?** (Circle to indicate your answer)	Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult