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Confidential Behavioral Health and Wellness Screening

PATIENT NAME: _____
DATE: _____

Hello, and Welcome,

Please thoughtfully complete the enclosed questionnaires assessing your current mood and thought patterns. Sunny Strasburg, LMFT, will review and go over these screening tests at your next appointment. Thank you for your time.

Sincerely,

_____
Sunny Strasburg, LMFT
Licenced Marriage and Family Therapist

Disclaimer: These screening tools are to help determine if you might benefit from professional mental health services. They are not intended as diagnosis or treatment of any specific illness or disorder, and, by completing this screening, you agree that (1) the results will only be used as a basis for discussion with a qualified mental health provider to help determine whether you might benefit from further testing, diagnostic evaluation and possible treatment, (2) for an accurate diagnosis of a mental health disorder, you should seek a full evaluation from a qualified health care provider, and (3) MOH and its providers disclaim any liability, loss or risk incurred as a consequence, directly or indirectly, fmo the use and application of these screens.

Generalized Anxiety Disorder 7-item (GAD-7) scale

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

0= Not at all sure
1= Several days
2= Over half the days
3= 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'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

Add the score for each column + + +
Total Score *(add your column scores)* =
If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?
Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*

***0*= Not at all**
1= More than half the days
2- Nearly every day
3= 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 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
Several days **9.** Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+ _____ + _____ + _____ =Total Score: _____**

If you checked off any problems, 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
□ **Somewhat difficult**
□ **Very difficult**
□ **Extremely difficult**

PTSD Checklist for *DSM-5*

Version date: 14 August 2013

Reference: Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for DSM-5 (PCL-5) – Standard* [Measurement instrument]. Available from http://www.ptsd.va.gov/

URL:
http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

PCL-5

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:

0= Not at all 2= Somewhat 4= Extremely

1. Repeated, disturbing, and unwanted memories of the stressful experience

0 1 2 3 4

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2. Repeated, disturbing dreams of the stressful experience?

0 1 2 3 4

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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

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4. Feeling very upset when something reminded you of the stressful experience?

0 1 2 3 4

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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

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6. Avoiding memories, thoughts, or feelings related to the stressful experience?

0 1 2 3 4

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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

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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

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10. Blaming yourself or someone else for the stressful experience or what happened after it?

0 1 2 3 4

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11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?

0 1 2 3 4

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12. Loss of interest in activities that you used to enjoy?

0 1 2 3 4

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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

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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

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18. Feeling jumpy or easily startled?

0 1 2 3 4

---

19. Having difficulty concentrating?

0 1 2 3 4

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20. Trouble falling or staying asleep?

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