Adult Behavioral Health Screen

INFORMATION FOR YOUR DOCTOR

Physical and emotional health go together. You can help us provide you with the best health care possible by answering these questions. Please circle the box that best describes you. If you do not wish to answer a question, you can leave it blank.

Your Name_____ **Today's Date:** _____

PHQ-2+1 ***Please circle the answer that best describes you during the past two weeks***	**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. Thinking that you would be better off dead or that you want to hurt yourself in some way	**(0)**	**(1)**	**(2)**	**(3)**

AUDIT, NM-ASSIST

Please circle the answer that best describes your use of alcohol or drugs. Drugs include all kinds of street drugs, marijuana, meth, cocaine, or prescription drugs such as tranquilizers or pain killers that are not taken as directed by your doctor.

1. How often do you drink alcohol?	**Never** **0**	**Monthly or less** **1**	**2-4 times a month** **2**	**2-3 times a week** **3**	**4 or more times a week** **4**
2. How many drinks of alcohol do you have on a typical day? (leave blank if you don't drink alcohol)	**1 or 2 drinks a day** **0**	**3 or 4 drinks a day** **1**	**5 or 6 drinks a day** **2**	**7 to 9 drinks a day** **3**	**10 or more drinks a day** **4**
3. In the past year did you have 6 or more drinks* of alcohol in one day if you are male; 5 or more if you are female? *one *drink means 12 oz. of beer, 1.5 oz. of liquor or 5 oz. of wine*	**Never** **0**	**Less than Monthly** **1**	**Monthly** **2**	**Weekly** **3**	**Daily or almost daily** **4**
4. In the past 3 months, how often have you used marijuana, other drugs or nonmedical use of prescription drugs?	**Never** **0**	**Less than Monthly** **2**	**Monthly** **3**	**Weekly** **4**	**Daily or almost daily** **6**
5. In the past 3 months, how often have you had a strong desire or urge to use alcohol or drugs	**Never** **0**	**Less than Monthly** **3**	**Monthly** **4**	**Weekly** **5**	**Daily or almost daily** **6**
6. In the past 3 months, has your use of alcohol or drugs led to health, social, legal or financial problems?	**Never** **0**	**Less than Monthly** **4**	**Monthly** **5**	**Weekly** **6**	**Daily or almost daily** **7**
7. In the past 3 months, how often have you failed to do what was normally expected of you because of your use of alcohol or drugs?	**Never** **0**	**Less than Monthly** **5**	**Monthly** **6**	**Weekly** **7**	**Daily or almost daily** **8**
8. Is fighting, violence or fear of being hurt a big problem in your home? (circle your answer)				**YES**	**NO**
9. Are there personal, emotional, or family problems and concerns that you would like to talk about privately with your doctor? (circle your answer)				**YES**	**NO**
10. Are you currently receiving services from a psychologist, psychiatrist, substance abuse program, mental health program or counselor? (circle your answer)				**YES**	**NO**

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Patient's Name_____ Screening Date_____

Screening Results

PHQ-2 for depression was

☐ negative ☐ positive ☐ positive for suicidal ideation

AUDIT for alcohol use was

☐ negative ☐ positive

Drug use screen was

☐ negative ☐ positive

Symptoms endorsed on patient's drug and alcohol screen

☐ do not result in functional impairment.

☐ result in functional impairment.

Endorsed fighting, violence, or fear of being hurt as a problem in the home:

☐ No ☐ Yes

Other personal, emotional, or family problems:

☐ No ☐ Yes- Concern was _____

Patient currently followed by a mental health provider.

☐ No ☐ Yes- Provider is _____

Screening Summary

Patient's overall screen was:

☐ negative.

☐ positive, but patient is already followed by a mental health provider.

☐ positive and warrants further monitoring.

☐ positive and warrants further assessment.

Intervention

☐ Reviewed screening results with patient/family.

☐ Discussed with patient/family impact of screening results on patient's health & need for:

☐ continued monitoring of patient's symptoms.

☐ further assessment by a behavioral health provider.

☐ patient to follow-up with patient's current mental health provider.

☐ Patient/family given copy of screening results.

Referral

☐ No referral made at this time.

☐ Referred patient to in house Behavioral Health/ Pediatric Psychology service for further assessment and treatment recommendations.

☐ Referred patient to_____

☐ Patient/family has appointment_____

☐ Patient/family given Behavioral Health contact (800) 652-2010 to call for assistance with location a behavioral health provider to conduct further assessment.

Comments

_____

_____

_____

Physician signature:_____ Date:_____