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Annual Questionnaire

FIRST NAME MIDDLE INITIAL LAST NAME
PATIENT'S NAME

DOB

Over the last 2 weeks, how often have you been bother by any of the following problems?

	Not at All	Several Days	More than half a Days	Nearly Every Day
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 the opposite, 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 of hurting yourself in some way	◯	◯	◯	◯

Did you have a drink containing alcohol in the past year? ◯ Yes ◯ No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

◯ Never ◯ Monthly or less ◯ 2 to 4 times a month ◯ 2 to 3 times a week ◯ 4 or more times a week

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

◯ 1 or 2 ◯ 3 or 4 ◯ 5 or 6 ◯ 7 to 9 ◯ 10 or more

If 'Yes' : How often did you have six or more drinks on one occasion in the past year?

◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily

Have you used drugs other than those for medical reason in the past 12 months? ◯ Yes ◯ No

If 'Yes' please list the drugs you have used in the past month _____

How often have you used these drugs? ◯ Monthly or less ◯ Weekly ◯ Daily or almost daily

Do you inject drugs? ◯ Yes ◯ No

Have you ever been in treatment for a drug problem ◯ Yes ◯ No

Date: