Place Sticker Here

Student Health & Wellness Center
Annual Questionnaire

Brief health screen

We ask all of our adult patients about substance use and mood because these factors can affect your health. Your answers on this form will remain confidential.

Mood

	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?		
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?		
Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?		

If you answered yes to one of the above question, please complete the PHQ-9 screening on the next page

Alcohol

	None	1 or more
How many times in the past year have you had 4 or more drinks in a day?		

* If you answered 1 or more to the above question, please complete the AUDIT screening on page 3*

Drugs

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for a non-medical use?		

* If you answered 1 or more to the above question, please complete the DAST screening on page 4*

Food Insecurity Screening

	No	Yes
Within the past 12 months, I worried whether my food would run out before I got money to buy more?		
Within the past 12 months, the food I bought did not last and I did not have money to get more?		

Patient Health Questionnaire (PHQ-9)

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

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead, or of hurting yourself				

Add columns: ______ + ______ + ______

TOTAL: ______

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
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?				

Alcohol Screening Questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals: 1 12 oz. beer 5 oz. wine 1.5 oz liquor (one shot)

How often do 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
How many drinks containing alcohol do you have on a typical day whne you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found that you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

I II III IV
M: 0-4 5-14 15-19 20+
W: 0-3 4-12 13-19 20+

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

☐ Methamphetamines (speed, crystal)
☐ Cannabis (marijuana, pot)
☐ Inhalants (paint thinner, aerosol, glue)
☐ Tranquilizers (valium)
☐ cocaine
☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ hallucinogens (LSD, mushrooms)
☐ other___________________________________

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

	No	Yes
Have you used drugs other than those required for medical reasons?		
Do you abuse more than one drug at a time?		
Are you unable to stop using drugs when you want to?		
Have you ever had blackouts or flashbacks as a result of drug use?		
Do you ever feel bad or guilty about your drug use?		
Does your spouse (or parents) ever complain about your involvement with drugs?		
Have you neglected your family because of your use of drugs?		
Have you engaged in illegal activities in order to obtain drugs?		
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?		
	0	1

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+