Columbia Screener (CS) - Recent

Patient Name_____ DOB_____ Date:_____

Columbia Screen	**Prior 1 Month**	
	YES	**NO**
Answer Questions 1 and 2		
1) ***In the last month, have you wished you were dead or wished you could go to sleep and not wake up?***	☐	☐
2) ***In the last month, have you actually had any thoughts of killing yourself?***	☐	☐
If YES to 2, Continue to questions 3, 4, 5, and 6. **If NO to 2, go directly to question 6 on behavior.**		
3) ***In the last month, have you been thinking about how you might do this?***	☐	☐
4) ***In the last month, have you had these thoughts and had some intention of acting on them?***	☐	☐
5) ***In the last month, have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?***	☐	☐
	Lifetime	
6) ***In your life, have you ever done anything, started to do anything, or prepared to do anything to end your life?***	**YES**	**NO**
If NO, screen is finished.	☐	☐
	Past 3 Months	
	YES	**NO**
If YES, ***<u>Was this within the past 3 months?</u>***	☐	☐

Full Name:_____ DOB:_____Date:_____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**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 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

(*For office coding: Total Score T*____ = ____ + ____ + ____)

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:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	☐	☐	☐	☐	☐
2. Repeated, disturbing dreams of the stressful experience?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
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
4. Feeling very upset when something reminded you of the stressful experience?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
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
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
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
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
10. Blaming yourself or someone else for the stressful experience or what happened after it?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12. Loss of interest in activities that you used to enjoy?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
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
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
18. Feeling jumpy or easily startled?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
19. Having difficulty concentrating?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
20. Trouble falling or staying asleep?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Full Name:_____ DOB_____ Date:_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Full Name:_____ **DOB:**_____ **Date:**_____

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
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's 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 hurting yourself in some way	0	1	2	3

10. 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	____ ____ ____ ____

To be completed by Tech: Add Row:

Total: + +

Mental Health Clinic Barksdale AFB, LA 71110

Name:_____ DOB:_____ Date:_____

AUDIT-C

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?

☐ A. Never
☐ B. Monthly or less
☐ C. Two to four times a month
☐ D. Two to three times per week
☐ E. Four or more times a week

Score: _____

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ A. 1 or 2 ☐ B. 3 or 4 ☐ C. 5 or 6 ☐ D. 7 to 9 ☐ E. 10 or more

Score: _____

3. How often do you have six or more drinks on one occasion?

☐ A. Never
☐ B. Less than Monthly
☐ C. Monthly
☐ D. Two to three times per week
☐ E. Four or more times a week

Score: _____

FOR CLINIC USE ONLY
TOTAL SCORE
Add the number for each question to get your total score. _____
Scoring Key:
A=0 B=1 C=2 D=3 E=4