

PATIENT FORM

Memory and Brain Wellness Clinic PHQ-9, GAD-7 & Patient Concerns

Important: This form is to be filled out by the **PATIENT**. Please fill out both front and back. If the patient is unable to fill out this form, please leave it blank.

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?		Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1	Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 (0)	Somewhat difficult (1)	Very difficult (2)	Extremely difficult (3)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROVIDER SIGNATURE	PRINT NAME	PAGER	NPI	TIME	DATE
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PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

M&BW PATIENT QUESTIONNAIRE

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WHITE - MEDICAL RECORD

Over the last 2 weeks , how often have you been bothered by any of the following problems?		Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1	Feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Being so restless that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 (0) <input type="checkbox"/>		Somewhat difficult (1) <input type="checkbox"/>		Very difficult (2) <input type="checkbox"/>	
				Extremely difficult (3) <input type="checkbox"/>	

Among the things listed below, what describes your feelings today (check all that apply)?	
<input type="checkbox"/>	I am concerned about my memory.
<input type="checkbox"/>	I am concerned about my physical health.
<input type="checkbox"/>	I am worried about my safety at home.
<input type="checkbox"/>	This clinic visit was the idea of somebody else. I am not sure I need or want to be here today.
<input type="checkbox"/>	At today's visit, I want to talk about (please fill in any additional concerns not listed above):

This section filled by staff only	New <input type="checkbox"/>	Return <input type="checkbox"/>	Provider						
			TG <input type="checkbox"/>	KDR <input type="checkbox"/>	RK <input type="checkbox"/>	SDM <input type="checkbox"/>	KC <input type="checkbox"/>	AH <input type="checkbox"/>	EL <input type="checkbox"/>
Diagnosis #1			Diagnosis #2				Diagnosis #3		

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UW Medicine
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M&BW PATIENT QUESTIONNAIRE

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H2819

WHITE - MEDICAL RECORD

PATIENT FORM

Memory and Brain Wellness Clinic

AUDIT

Important: This form is to be filled out by the **PATIENT**. If the patient is unable to fill out this form, please leave it blank.

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. (Staff: add up score per item for the total)

For each question, place an X in one box that best describes your answer.

		0	1	2	3	4
1	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
2	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3	How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5	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
6	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
7	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
8	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
9	Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10	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, during the last year

This section filled by staff only	New <input type="checkbox"/>	Return <input type="checkbox"/>	Provider: <input type="checkbox"/> TG <input type="checkbox"/> KDR <input type="checkbox"/> RK <input type="checkbox"/> SDM <input type="checkbox"/> KC <input type="checkbox"/> AH <input type="checkbox"/> EL <input type="checkbox"/> AMC
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