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 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	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	☐	☐	☐	☐

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)
☐	☐	☐	☐

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PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc.

PLACE PATIENT LABEL HERE

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	☐	☐	☐	☐
2	Not being able to stop or control worrying	☐	☐	☐	☐
3	Worrying too much about different things	☐	☐	☐	☐
4	Trouble relaxing	☐	☐	☐	☐
5	Being so restless that it is hard to sit still	☐	☐	☐	☐
6	Becoming easily annoyed or irritable	☐	☐	☐	☐
7	Feeling afraid as if something awful might happen	☐	☐	☐	☐

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)
☐	☐	☐	☐

Among the things listed below, what describes **your feelings today** (check all that apply)?	
☐	I am concerned about my memory.
☐	I am concerned about my physical health.
☐	I am worried about my safety at home.
☐	This clinic visit was the idea of somebody else. I am not sure I need or want to be here today.
☐	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**	**Return**	**Provider**							
			TG	KDR	RK	SDM	KC	AH	EL	AMC
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Diagnosis #1	**Diagnosis #2**	**Diagnosis #3**

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

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PATIENT FORM
Memory and Brain Wellness Clinic
AUDIT

<u>Important:</u> 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** ☐	**Return** ☐	**Provider:** ☐**TG** ☐**KDR** ☐**RK** ☐**SDM** ☐**KC** ☐**AH** ☐**EL** ☐**AMC**

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Babor, T.F.; de la Fuente, J.R.; Saunders, J.; and Grant, M. AUDIT. *The Alcohol Use Disorders Identification Test. Guidelines for use in primary health care*. Geneva, Switzerland: World Health Organization, 1992

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