Anxiety Survey

Generalized Anxiety Disorder (GAD-7) Anxiety Scale

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

Scoring: Sum the numerical answers to questions number 1 through 7.

Score	Severity
0-4	None-Minimal
5-9	Mild
10-14	Moderate
15-21	Severe

If you are feeling overwhelmed, depressed or unable to do the things you once enjoyed, it may be time to pause and assess your emotional health.

Please note that suicidality is not assessed in this survey.

If you feel you may be at risk or have thoughts about harming yourself or others, please seek immediate help from a medical professional.
Call 911 or the 24/7 Crisis Hotline at 1-844-4CRISIS (1-844-427-4747).

Depression Survey

Patient Health Questionnaire (PHQ-9) Depression Scale

Over the last 2 weeks, how often have you been bothered by 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 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 people 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 of hurting yourself in some way	0	1	2	3

Scoring: Sum the numerical answers to questions number 1 through 9.

Score	Severity
0-4	None-Minimal
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

If you are feeling overwhelmed, depressed or unable to do the things you once enjoyed, it may be time to pause and assess your emotional health.

Please note that suicidality is not assessed in this survey.

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Substance Abuse Survey

Self-Administered Screening Instrument

The questions that follow are about your use of alcohol and other drugs. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

Question	Response
1. Have you used alcohol or other drugs (Such as wine, beer, hard liquor, pot, coke, heroine or other opioids, uppers, downers, hallucinogens, or inhalants)	*Y or N*
2. Have you felt that you use too much alcohol or other drugs?	*Y or N*
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?	*Y or N*
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program)	*Y or N*
5. Have you had any health problems? For example, have you: - Had blackouts or other periods of memory loss? - Injured your head after drinking or using drugs? - Had convulsions, delirium tremens ("DTs")? - Had hepatitis or other liver problems? - Felt sick, shaky or depressed when you stopped using alcohol or drugs? - Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs? - Been injured after drinking or using? - Used needles to shoot drugs?	*Y or N*
6. Has drinking or other drug use caused problems between you and your family or friends?	*Y or N*
7. Has your drinking or other drug use caused problems at school or at work?	*Y or N*
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft or drug possession)	*Y or N*
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?	*Y or N*

Assessment continues on the next page ➲

Substance Abuse Survey

Self-Administered Screening Instrument (Continued)	
10. Are you needing to drink or use drugs more and more to get the effect you want?	*Y or N*
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?	*Y or N*
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?	*Y or N*
13. Do you feel bad or guilty about your drinking or drug use?	*Y or N*
The next questions are about your lifetime experiences:	
14. Have you ever had a drinking or other drug problem?	*Y or N*
15. Have any of your family members ever had a drinking or drug problem?	*Y or N*
16. Do you feel that you have a drinking or drug problem now?	*Y or N*

Scoring: Questions 1 and 15 are **not** scored.
Give yourself 1 point for every **Yes** circled and add sum of questions 2 through 14 and 16.

Score	Degree of Risk for Substance Abuse
0-1	None-Low
2-3	Minimal
≥4	Moderate to High: Possible need for further assessment

Please note that suicidality is not assessed in this survey.

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