Annual Behavioral Health Assessment

Patient Name: ___________________________________ Date: _____________

CAGE-AID Questionnaire

#	Question	Yes	No
1	Have you ever felt that you ought to cut down on your drinking or drug use?		
2	Have people annoyed you by criticizing your drinking or drug use?		
3	Have you ever felt bad or guilty about your drinking or drug use?		
4	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		

Note: Each affirmative response earns one point. One point indicates a possible problem. Two points or more indicate a probable problem and you should consider referral to an appropriate provider for further evaluation and treatment.

PHQ-2 Questionnaire

#	Question	Yes	No
1	During the past month, have you often been bothered by feeling down, depressed, or hopeless?		
2	During the past month, have you often been bothered by little interest or pleasure in doing things?		

Note: If the response is “yes” to either question, consider referral to appropriate provider for further evaluation.

Mini-Mental State Exam (MMSE)

#	Question	Yes	No
1	**Orientation:** What is the (year) (season) (date) (day) (month)? Where are we (state) (country) (town) (hospital) (floor)?		
2	**Registration:** Name three objects, then ask the patient to repeat all three.		
3	**Attention & Calculation:** Serial 7’s up to 5 answers e.g. 7, 14, 21, 28, 35. Spell the word “world” backwards.		
4	**Recall:** Ask for the 3 objects in #2 repeated.		
5	**Language:** Repeat the following “No ifs, and, or buts”. Follow a 3-stage command “Take a paper in your hand, fold it in half, and put it on the floor.” Copy a shown five sided (pentagon) figure.		

Note: If the response is “no” (unable to) to any of the tasks, consider referral to appropriate provider for further evaluation.

Anxiety Screening

#	Question	Yes	No
1	Do you worry a lot?		
2	Are you experiencing fear of losing control?		
3	Do you avoid situations because they make you anxious?		
4	Do you persistently re-live events that upset you?		

Note: If the response is “yes” to any of the questions, consider referral to appropriate provider for further evaluation.

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Sleeping Habits Assessment

#	Question	Yes	No
1	Do you sleep less than 6 hours at a time?		
2	In the last 7 days, have you had any changes to your sleeping pattern?		
3	Do you feel tired often?		
4	Do you have difficulty falling or staying asleep?		

Note: If the response is “yes” to any of the questions, consider referral to appropriate provider for further evaluation

Appetite Assessment

#	Question	Yes	No
1	In the last 7 days, has your appetite been good?		
2	Do you eat three main meals a day?		
3	Do you have enough food?		
4	Have you lost or gained weight in the last 30-days?		

Note: If the response is “yes” to any of the questions, consider referral to appropriate provider for further evaluation

PC-PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the last month you:

#	Question	Yes	No
1	Have you had nightmares about it or thought about it when you did not want to?		
2	Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?		
3	Were constantly on guard, watchful, or easily startled?		
4	Felt numb or detached from others, activities, or your surroundings?		

Note: If the response is “yes” to any of the questions, consider referral to appropriate provider for further evaluation

Domestic Violence Screen

#	Question	Yes	No
1	Within the past year have you been hit, slapped, kicked or otherwise physically hurt by someone?		
2	Are you in a relationship with a person who threatens or physically hurts you?		
3	Has anyone forced you to have sexual activities that made you feel uncomfortable?		

Note: If the response is “yes” to any of the questions, consider referral to appropriate provider for further evaluation

Tobacco Use Screen

#	Question	Yes	No
1	Within the past three months, have you smoked or chewed any tobacco products?		
2	Have you considered quitting tobacco use?		
3	Would you like assistance in smoking cessation?		

Note: If the response is “yes” to any of the questions, consider referral to a smoking cessation program