EastValley
COMMUNITY HEALTH CENTER

How am I feeling today?

Patient Name: ______________________________

DOB: ___/____/____ **Today's Date:** ___________

»»» **Please mark an X in the appropriate box.** **(Your responses are confidential)**

In the past <u>2 weeks (14 days)</u>, how often have you been bothered by these problems?	Not at All 0	Several Days 1	More than 7 Days 2	Nearly Every Day 3
1. Little interest or no pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling asleep, staying asleep or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
7. Trouble concentrating on things such as reading the newspaper or watching television				
8. Moving or speaking slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
9. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Add the score for each column				

Total Score: __________

In the past <u>2 weeks (14 days)</u>, how often have you been bothered by these problems?	Not at All 0	Several Days 1	More than 7 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's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				
Add the score for each column				

Total Score: ________

My Habits

For each question, place an X in the 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 to 4 times a month	2 to 3 times a week	4 or more times a week
2. How many alcoholic drinks 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 drink more than 5 alcoholic drinks a day?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Total Score: ___________

For each question, place an X in the box that best describes your answer.	My Answers	
1. Do you feel you ought to CUT down on your current drug use?	YES	NO
2. Do people annoy you by CRITICIZING your current drug use?	YES	NO
3. Do you feel bad or guilty about your current drug use?	YES	NO
4. Do you use drugs first thing in the morning to steady your nerves?	YES	NO

Opioid Dependence is a national crisis but we can help.

MAT is a program for people addicted to prescription drugs and/or heroin.

When you are in pain, which of the following medications have you used? *(Please mark each one with an X)*

☐ Vicodin ☐ Norco ☐ OxyContin ☐ Dilaudid ☐ Hydrocodine ☐ Hydromorphone ☐ Morphine

☐ Tramadol ☐ Fentanyl ☐ N/A ☐ Other: ______________________________,

Would you like to know more about the MAT program? ☐ **YES** ☐ **NO**