Recommendations for Comprehensive Adult Health Assessment

AGE	21y	24y	35y	40y	45y	49y	50y	65y	70y	75y	79y	80y	> 80y
FORMAT/DOCUMENTATION													
Biographical Info	21 to 99 years												
Emergency Contact	21 to 99 years												
Assigned PCP	21 to 99 years												
Primary Language	21 to 99 years												
Medical Interpreter	21 to 99 years												
Signed Notice of Privacy	21 to 99 years												
Allergies	21 to 99 years												
Chronic Problems	21 to 99 years												
Continuous Medications	21 to 99 years												
Advanced Healthcare Directive	21 to 99 years												
PHYSICAL EXAM	21 to 99 years												
MEMBER RISK ASSESSMENT	21 to 99 years												
SCREENINGS: ALL AGES & GENDERS													
Alcohol/Drug/Tobacco Use	21 to 99 years												
Blood Pressure	21 to 99 years												
Depression	21 to 99 years												
Hepatitis B	21 to 99 years												
Obesity	21 to 99 years												
Sexually Transmitted Infections	21 to 99 years												
Tuberculosis	21 to 99 years												
SCREENINGS FOR MEN + WOMEN													
Skin Cancer Counseling	21 to 24 years												
HIV	21 to 65 years												
Hepatitis C	21 to 79 years												
Diabetes + Comprehensive Care			35 to 70 years										
Dyslipidemia				40 to 75 years									
Colorectal Cancer					45 to 75 years								
Lung Cancer							50 to 80 years						
SCREENINGS FOR WOMEN ONLY													
Folic Acid Counseling	21 to 49 years												
Intimate Partner Violence	21 to 49 years												
Cervical Cancer	21 to 65 years												
Breast Cancer							50 to 75 years						
SCREENINGS FOR MEN ONLY													
Abdominal Aneurysm													
IMMUNIZATIONS													
Annual Flu Vaccine	21 to 99 years												
Tdap Vaccine	21 to 99 years												
Varicella/MRR (Evidence of Immunity)	21 to 99 years												
Zoster Vaccine							50 to 99 years						
Pneumococcal Vaccine								65 to 99 years					

green box – age range for assessment peach box – age range if applicable *This document is a quick guide. Please refer to DHCS standards for details.*

Recommended and/or Required Screening Tools
(Check bookmarks or click page number to jump to page)

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

PATIENT FORM (short version)

Please answer the following.

HOUSING

1. What is your housing situation today?[1]
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future
   - ☐ I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[1]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)[1]
   - ☐ Yes, it has kept me from medical appointments or getting medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[1]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

PERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

8. How often does anyone, including family, insult or talk down to you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

9. How often does anyone, including family, threaten you with harm?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

10. How often does anyone, including family, scream or curse at you?[1]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Fairly often
    - ☐ Frequently

ASSISTANCE

11. Would you like help with any of these needs?
    - ☐ Yes
    - ☐ No

Questions 1-10 are reprinted with permission from the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

REFERENCE:

1. Billioux A, Verlander K, Anthony S, and Alley D. National Academy of Medicine. Standardized screening for health-related social needs in clinical settings: the accountable health communities screening tool. National Academies Press. Washington, D.C. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf. Accessed November 14, 2017.

Supported in part by a grant from the AAFP Foundation

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
Did you lose a parent through divorce, abandonment, death, or other reason?	☐
Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
Did you live with anyone who went to jail or prison?	☐
Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
Did you feel that no one in your family loved you or thought you were special?	☐
Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? ◯ **Not Much** ◯ **Some** ◯ **A Lot**

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

5/5/20

Patient name: _____

Testing date: _____

GPCOG

STEP 1 – PATIENT EXAMINATION

Unless specified, each question should only be asked once.

Name and address for subsequent recall test

I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington. (Allow a maximum of 4 attempts.)

		Correct	Incorrect
Time orientation			
1.	*What is the date?* (exact only)	☐	☐
Clock drawing (use blank page)			
2.	*Please mark in all the numbers to indicate the hours of a clock.* (correct spacing required)	☐	☐
3.	*Please mark in hands to show 10 minutes past eleven o'clock.* (11.10)	☐	☐
Information			
4.	*Can you tell me something that happened in the news recently?* (Recently = in the last week. If a general answer is given, e.g. "war", "lot of rain", ask for details. Only specific answer scores.)	☐	☐
Recall			
5.	*What was the name and address I asked you to remember?*		
	John	☐	☐
	Brown	☐	☐
	42	☐	☐
	West (St)	☐	☐
	Kensington	☐	☐

Add the number of items answered correctly: **Total score:** ☐ **out of 9**

9	**No significant cognitive impairment** Further testing is not necessary
5 – 8	**More information required** Proceed with informant interview in step 2 on next page
0 – 4	**Cognitive impairment is indicated** Conduct standard investigations

Brodaty et al, *JAGS* 2002; 50:530-534

Patient name: _____

Testing date: _____

GPCOG

STEP 2: INFORMANT INTERVIEW

Informant name: _____

Relationship to patient, i.e. informant is the patient's: _____

Ask the informant:

Compared to 5–10 years ago,	YES	NO	Don't know	N/A
1. *Does the patient have more trouble remembering things that have happened recently than s/he used to?*	☐	☐	☐	
2. *Does s/he have more trouble recalling conversations a few days later?*	☐	☐	☐	
3. *When speaking, does s/he have more difficulty in finding the right word or tend to use the wrong words more often?*	☐	☐	☐	
4. *Is s/he less able to manage money and financial affairs (e.g. paying bills and budgeting)?*	☐	☐	☐	☐
5. *Is s/he less able to manage his or her medication independently?*	☐	☐	☐	☐
6. *Does s/he need more assistance with transport (either private or public)?* (If the patient has difficulties only due to physical problems, e.g. bad leg, tick 'no'.)	☐	☐	☐	☐

Add the number of items answered with 'NO', 'Don't know' or 'N/A':

Total score: ☐ **out of 6**

4 – 6	**No significant cognitive impairment** Further testing is not necessary
0 – 3	**Cognitive impairment is indicated** Conduct standard investigations

When referring to a specialist, mention the individual scores for the two GPCOG test steps:

STEP 1 **Patient examination:** __ **/ 9**

STEP 2 **Informant interview:** __ **/ 6** or **N/A**

Brodaty et al, *JAGS* 2002; 50:530-534

Nombre del paciente: _____

Fecha: _____

GPCOG

ETAPA 1 – EXAMEN DEL PACIENTE

Cada pregunta debe hacerse una sola vez, a no ser que se especifique lo contrario.

Nombre y dirección para hacer una prueba de recuperación de memoria

Le voy a dar un nombre y una dirección. Despues de decirlo, quiero que lo repita. Recuerde este nombre y dirección porque se lo volveré a preguntar en algunos minutos: Juan Díaz, calle Mayor 42, Soria. (Permitir hasta 4 ensayos, pero no puntuar todavia.)

		Correcto	Incorrecto
Orientación en tiempo			
1.	*¿Qué fecha es?* (respuesta exacta)	☐	☐
Dibujar un reloj (emplear un círculo en el reverse de esta página)			
2.	*Por favor marque/dibuje todos los números que indican las horas de un reloj.* (espaciado correcto)	☐	☐
3.	*Por favor marque/ dibuje las agujas/manecillas que indican las 11 y las 10.*	☐	☐
Información			
4.	*¿Puede usted decirme alguna noticia reciente?* (Reciente = de la última semana. Ante una respuesta inespecífica, como "guerra", "mucha lluvia", pedir mas información. Solamente las respuestas specificias son correctas.)	☐	☐
Memoria			
5.	*¿Cuál es el nombre y la dirección que le pedí que recordará?*		
	Juan	☐	☐
	Díaz	☐	☐
	Mayor (calle)	☐	☐
	42	☐	☐
	Soria	☐	☐
Añadir las respuestas correctas:		**Resultado:** ☐	**de los 9**

9	**No hay deterioro cognitivo observable** No es necesario conducir investigaciones o estudios estándares
5 – 8	**Mas información es necesaria** Proceda con la etapa 2: entrevistar al familiar o cuidador
0 – 4	**Se indica deterioro cognitivo** Conduzca investigaciones o estudios estándares

Nombre del paciente: _____

Fecha: _____

GPCOG

ETAPA 2 – ENTREVISTA AL FAMILIAR O CUIDADOR

Nombre del informador: _____

Relación con el paciente: _____

Haga las siguientes preguntas:

Comparado a hace 5–10 años,	SI	NO	No sabe	N/A
1. *¿Tiene el paciente más dificultades para recordar hechos recientes?*	☐	☐	☐	
2. *¿Tiene el paciente más dificultades para recordar conversaciones que han tenido lugar en los días previos?*	☐	☐	☐	
3. *Cuando habla ¿tiene el paciente más dificultades para encontrar la palabra adecuada, o se equivoca con las palabras mas a menudo?*	☐	☐	☐	
4. *¿Es el paciente menos capaz de manejar el dinero y los asuntos económicos (p.ej. pagar los recibos, hacer un presupuesto)?*	☐	☐	☐	☐
5. *¿Es el paciente menos capaz de manejar su medicación de forma independiente?*	☐	☐	☐	☐
6. *¿Necesita el paciente más asistencia para desplazarse (en transporte público o privado)?* (Si el paciente experimenta dificultades debido a problemas físicos p.ej. un problema en la pierna, marque 'NO'.)	☐	☐	☐	☐

Añadir las respuestas 'NO', 'No sabe' o 'N/A (no aplicable)':

Resultado: ☐ **de los 6**

4 – 6 **No hay deterioro cognitivo observable**
No es necesario conducir investigaciones

0 – 3 **Se indica deterioro cognitivo**
Conduzca investigaciones o estudios estándares

Al ser referido a un especialista, cita los dos resultados de cada etapa del GPCOG:

ETAPA 1 **Examen del paciente:** __ **/ 9**

ETAPA 2 **Entrevista al informador:** __ **/ 6** o **N/A**

Mini-Cog™

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	**Version 2**	**Version 3**	**Version 4**	**Version 5**	**Version 6**
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

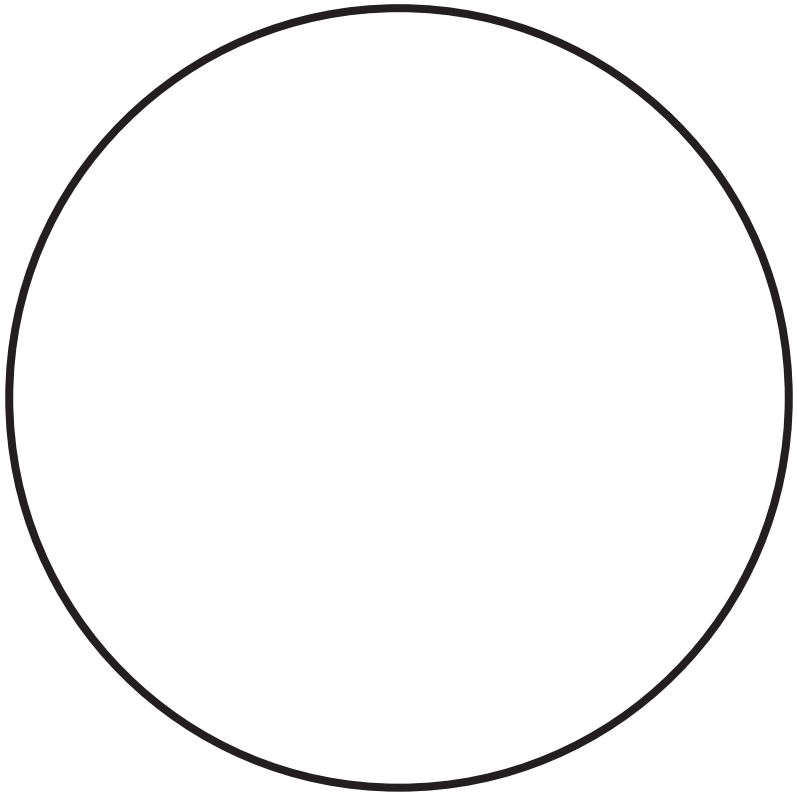
Word List Version: _____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Clock Drawing

ID: _____ Date: _____



References

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2. Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006;21: 349–355.
3. Lessig M, Scanlan J et al. Time that tells: Critical clock-drawing errors for dementia screening. Int Psychogeriatr. 2008 June; 20(3): 459–470.
4. Tsoi K, Chan J et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015; E1-E9.
5. McCarten J, Anderson P et al. Screening for cognitive impairment in an elderly veteran population: Acceptability and results using different versions of the Mini-Cog. J Am Geriatr Soc 2011; 59: 309-213.
6. McCarten J, Anderson P et al. Finding dementia in primary care: The results of a clinical demonstration project. J Am Geriatr Soc 2012; 60: 210-217.
7. Scanlan J & Borson S. The Mini-Cog: Receiver operating characteristics with the expert and naive raters. Int J Geriatr Psychiatry 2001; 16: 216-222.

AD8 Dementia Screening Interview

Patient ID#:_____
CS ID#:_____
Date:_____

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	**YES, A change**	**NO, No change**	**N/A, Don't know**
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. **Daily** problems with thinking and/or memory			
TOTAL AD8 SCORE			

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564

The AD8 Administration and Scoring Guidelines

A spontaneous self-correction is allowed for all responses without counting as an error.

The questions are given to the respondent on a clipboard for self–administration or can be read aloud to the respondent either in person or over the phone. It is preferable to administer the AD8 to an informant, if available. If an informant is not available, the AD8 may be administered to the patient.

When administered to an informant, specifically ask the respondent to rate change in the patient.

When administered to the patient, specifically ask the patient to rate changes in his/her ability for each of the items, ***without*** attributing causality.

If read aloud to the respondent, it is important for the clinician to carefully read the phrase as worded and give emphasis to note changes due to cognitive problems (not physical problems). There should be a one second delay between individual items.

No timeframe for change is required.

The final score is a sum of the number items marked "Yes, A change".

Interpretation of the AD8 (Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564)

A screening test in itself is insufficient to diagnose a dementing disorder. The AD8 is, however, quite sensitive to detecting early cognitive changes associated many common dementing illness including Alzheimer disease, vascular dementia, Lewy body dementia and frontotemporal dementia.

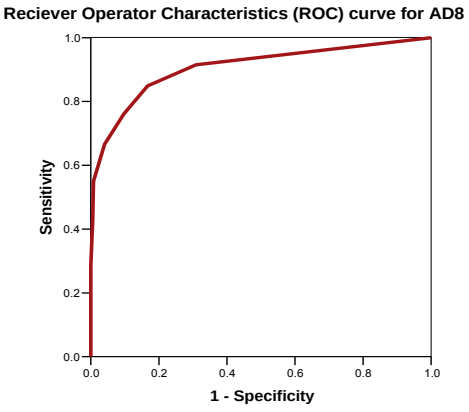
Scores in the impaired range (see below) indicate a need for further assessment. Scores in the "normal" range suggest that a dementing disorder is unlikely, but a very early disease process cannot be ruled out. More advanced assessment may be warranted in cases where other objective evidence of impairment exists.

Based on clinical research findings from 995 individuals included in the development and validation samples, the following cut points are provided:

- 0 – 1: Normal cognition
- 2 or greater: Cognitive impairment is likely to be present

Administered to either the informant (preferable) or the patient, the AD8 has the following properties:

- Sensitivity > 84%
- Specificity > 80%
- Positive Predictive Value > 85%
- Negative Predictive Value > 70%
- Area under the Curve: 0.908; 95%CI: 0.888-0.925



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Patient name: _____

Date of birth: _____

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

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?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five 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, in 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, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

I	II	III	IV
0-3	4-9	10-13	14+

(For the Provider)

Scoring and interpreting the AUDIT:

1. Each response has a score ranging from 0 to 4. All response scores are added for a total score.

2. The total score correlates with a risk zone, which can be circled on the bottom left corner.

Score	Zone	Explanation	Action
0-3	I – Low Risk	"Someone using alcohol at this level is at low risk for health or social complications."	Positive Health Message – describe low risk drinking guidelines
4-9	II – Risky	"Someone using alcohol at this level may develop health problems or existing problems may worsen."	Brief intervention to reduce use
10-13	III – Harmful	"Someone using alcohol at this level has experienced negative effects from alcohol use."	Brief Intervention to reduce or abstain and specific follow-up appointment (Brief Treatment if available)
14+	IV – Severe	"Someone using alcohol at this level could benefit from more assessment and assistance."	Brief Intervention to accept referral to specialty treatment for a full assessment

Positive Health Message: An opportunity to educate patients about the NIAAA low-risk drinking levels and the risks of excessive alcohol use.

Brief Intervention to Reduce Use: Patient-centered discussion that uses Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhance his/her motivation to change behavior. Brief interventions are typically 5-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention. The recommended behavior change is to cut back to low-risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication contraindications, etc.).

Brief Intervention to Reduce or Abstain (Brief Treatment if available) & Follow-up: Patients with numerous or serious negative consequences from their alcohol use, or patients who likely have an alcohol use disorder who cannot or are not interested in obtaining specialized treatment, should receive more numerous and intensive BIs with follow up. The recommended behavior change is to cut back to low-risk drinking levels or abstain from use. Brief treatment is 1 to 5 sessions, each 15-60 minutes. Refer for brief treatment if available. If brief treatment is not available, secure follow-up in 2-4 weeks.

Brief Intervention to Accept Referral: The focus of the brief intervention is to enhance motivation for the patient to accept a referral to specialty treatment. If accepted, the provider should use a proactive process to facilitate access to specialty substance use disorder treatment for diagnostic assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

More resources: www.sbirtoregon.org

***** Johnson J, Lee A, Vinson D, Seale P. "Use of AUDIT-Based Measures to Identify Unhealthy Alcohol Use and Alcohol Dependence in Primary Care: A Validation Study." Alcohol Clin Exp Res, Vol 37, No S1, 2013: pp E253–E259

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

1. Within the past year, how often did you have a drink of alcohol?

- ☐ a. Never
- ☐ b. Monthly (e.g. Special occasions/Rare)
- ☐ c. 2-4 times a month (e.g. 1x on weekend - “Fridays only” or “every other Thursday”)
- ☐ d. 2-3 times a week (e.g. weekends – Friday-Saturday or Saturday-Sunday)
- ☐ e. 4 or more times a week (e.g. daily or most days/week)

2. Within the past year, how many standard drinks containing alcohol did you have on a typical day?

- ☐ a. 1 or 2
- ☐ b. 3 or 4
- ☐ c. 5 or 6
- ☐ d. 7 to 9
- ☐ e. 10 or more

3. Within the past year, how often did you have six or more drinks on one occasion?

- ☐ a. Never
- ☐ b. Less than monthly
- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily

AUDIT-C is available for use in the public domain.

AUDIT-C - Overview

The AUDIT-C is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument.

Clinical Utility

The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders.

Scoring

The AUDIT-C is scored on a scale of 0-12.

Each AUDIT-C question has 5 answer choices. Points allotted are:
a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points

- **In men**, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- **In women**, a score of 3 or more is considered positive (same as above).
- However, when the points are all from Question #1 alone (#2 & #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy.[3]
- Generally, the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.

Psychometric Properties

For identifying patients with heavy/hazardous drinking and/or Active-DSM alcohol abuse or dependence

	Men[1]	Women[2]
≥3	Sens: 0.95 / Spec. 0.60	Sens: 0.66 / Spec. 0.94
≥4	Sens: 0.86 / Spec. 0.72	Sens: 0.48 / Spec. 0.99

For identifying patients with active alcohol abuse or dependence

≥ 3	Sens: 0.90 / Spec. 0.45	Sens: 0.80 / Spec. 0.87
≥ 4	Sens: 0.79 / Spec. 0.56	Sens: 0.67 / Spec. 0.94

1. *Bush K, Kivlahan DR, McDonell MB, et al. The AUDIT Alcohol Consumption Questions (AUDIT-C): An effective brief screening test for problem drinking. Arch Internal Med. 1998 (3): 1789-1795.*
2. *Bradley KA, Bush KR, Epler AJ, et al. Two brief alcohol-screening tests from the Alcohol Use Disorders Identification Test (AUDIT): Validation in a female veterans affairs patient population. Arch Internal Med Vol 163, April 2003: 821-829.*
3. *Frequently Asked Questions guide to using the AUDIT-C can be found via the website: www.oqp.med.va.gov/general/uploads/FAQ%20AUDIT-C*

The CRAFFT+N Questionnaire

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.	☐ # of days
2.	Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none.	☐ # of days
3.	Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Put "0" if none.	☐ # of days
4.	Use a **vaping device* containing nicotine and/or flavors**, or use any **tobacco products**†? Put "0" if none. **Such as e-cigs, mods, pod devices like JUUL, disposable vapes like Puff Bar, vape pens, or e-hookahs. †Cigarettes, cigars, cigarillos, hookahs, chewing tobacco, snuff, snus, dissolvables, or nicotine pouches.*	☐ # of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 5 BELOW, THEN STOP.**
- **If you put "1" or more for <u>Questions 1, 2, or 3</u> above, ANSWER QUESTIONS 5-10 BELOW.**
- **If you put "1" or more for <u>Question 4</u> above, ANSWER ALL QUESTIONS ON BACK PAGE.**

		Circle one	
5.	Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	**No**	**Yes**
6.	Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	**No**	**Yes**
7.	Do you ever use alcohol or drugs while you are by yourself, or ALONE?	**No**	**Yes**
8.	Do you ever FORGET things you did while using alcohol or drugs?	**No**	**Yes**
9.	Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	**No**	**Yes**
10.	Have you ever gotten into TROUBLE while you were using alcohol or drugs?	**No**	**Yes**

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent.

The following questions ask about your use of any **vaping devices containing nicotine and/or flavors**, or use of any **tobacco products***. Circle your answer for each question.

	Circle one
1. Have you ever tried to quit using, but couldn't?	**Yes** **No**
2. Do you vape or use tobacco now because it is really hard to quit?	**Yes** **No**
3. Have you ever felt like you were addicted to vaping or tobacco?	**Yes** **No**
4. Do you ever have strong cravings to vape or use tobacco?	**Yes** **No**
5. Have you ever felt like you really needed to vape or use tobacco?	**Yes** **No**
6. Is it hard to keep from vaping or using tobacco in places where you are not supposed to, like school?	**Yes** **No**
7. When you haven't vaped or used tobacco in a while (or when you tried to stop using)…	
a. did you find it hard to concentrate because you couldn't vape or use tobacco?	**Yes** **No**
b. did you feel more irritable because you couldn't vape or use tobacco?	**Yes** **No**
c. did you feel a strong need or urge to vape or use tobacco?	**Yes** **No**
d. did you feel nervous, restless, or anxious because you couldn't vape or use tobacco?	**Yes** **No**

**References:*

Wheeler, K. C., Fletcher, K. E., Wellman, R. J., & DiFranza, J. R. (2004). Screening adolescents for nicotine dependence: the Hooked On Nicotine Checklist. *J Adolesc Health*, *35*(3), 225–230;

McKelvey, K., Baiocchi, M., & Halpern-Felsher, B. (2018). Adolescents' and Young Adults' Use and Perceptions of Pod-Based Electronic Cigarettes. *JAMA Network Open*, *1*(6), e183535.

Questions 1-8 of the NIDA-Modified ASSIST V2.0

Instructions: Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

Question 1 of 8, NIDA-Modified ASSIST **In your *LIFETIME*, which of the following substances have you ever used?** ***Note for Physicians: For prescription medications, please report nonmedical use only.***	**Yes**	**No**
a. Cannabis (marijuana, pot, grass, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. Other – specify:		

- Given the patient's response to the Quick Screen, the patient *should not indicate* **"NO"** for all drugs in Question 1. If they do, remind them that their answers to the Quick Screen indicated they used an illegal or prescription drug for nonmedical reasons within the past year and then **repeat Question 1**. If the patient indicates that the drug used is not listed, please mark **'Yes'** next to 'Other' and continue to **Question 2** of the NIDA-Modified ASSIST**.**

- If the patient says **"Yes"** to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

Question 2 of 8, NIDA-Modified ASSIST 2. In the past three months, how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
• Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
• Cocaine (coke, crack, etc.)	0	2	3	4	6
• Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	2	3	4	6
• Methamphetamine (speed, crystal meth, ice, etc.)	0	2	3	4	6
• Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	2	3	4	6
• Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	2	3	4	6
• Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	2	3	4	6
• Street opioids (heroin, opium, etc.)	0	2	3	4	6
• Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	2	3	4	6
• Other – Specify:	0	2	3	4	6

- For patients who report **"Never"** having used any drug in the past 3 months: **Go to Questions 6-8**.
- For any recent **illicit or nonmedical prescription drug use**, go to **Question 3.**

3. In the past 3 months, how often have you had a strong desire or urge to use (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
b. Cocaine (coke, crack, etc.)	0	3	4	5	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	4	5	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	4	5	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	4	5	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	3	4	5	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	4	5	6
h. Street Opioids (heroin, opium, etc.)	0	3	4	5	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	4	5	6
j. Other – Specify:	0	3	4	5	6

4. During the past 3 months, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
b. Cocaine (coke, crack, etc.)	0	4	5	6	7
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	4	5	6	7
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	4	5	6	7
e. Inhalants (nitrous oxide, glue, gas, pain thinner, etc.)	0	4	5	6	7
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	4	5	6	7
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	4	5	6	7
h. Street opioids (heroin, opium, etc.)	0	4	5	6	7
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	4	5	6	7
j. Other – Specify:	0	4	5	6	7

5. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street Opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other – Specify:	0	5	6	7	8

Instructions: Ask Questions 6 & 7 for all substances **ever used** (i.e., those endorsed in the Question 1).

6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

Instructions: Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
  - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
  - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

Note: Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

Tally Sheet for scoring the full NIDA-Modified ASSIST:

Instructions: For each substance (labeled a–j), add up the scores received for questions 2-7 above. This is the Substance Involvement (SI) score. Do not include the results from either the Q1 or Q8 (above) in your SI scores.

Substance Involvement Score	Total (SI SCORE)
a. Cannabis (marijuana, pot, grass, hash, etc.)	
b. Cocaine (coke, crack, etc.)	
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	
d. Methamphetamine (speed, crystal meth, ice, etc.)	
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	
h. Street Opioids (heroin, opium, etc.)	
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	
j. Other – Specify:	

Use the resultant Substance Involvement (SI) Score to identify patient's risk level.

To determine patient's risk level based on his or her SI score, see the table below:

Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk

Patient Health Questionnaire-2 (PHQ-2)

Over the last *2 weeks*, how often have you been bothered by any of 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

For office coding: _____*0*_____*+*_____*+*_____*+*_____

= Total Score _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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 a 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

FOR OFFICE CODING __0__ **+** _____ **+** _____ **+** _____

=Total Score: _____

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	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Hospital Anxiety and Depression Scale (HADS)

Tick the box beside the reply that is closest to how you have been feeling in the past week.
Don't take too long over you replies: your immediate is best.

D	A		D	A	
		I feel tense or 'wound up':			**I feel as if I am slowed down:**
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			**I feel restless as I have to be on the move:**
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			**I get sudden feelings of panic:**
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			**I can enjoy a good book or radio or TV program:**
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions

Scoring:

Total score: Depression (D) _____ Anxiety (A) _____

0-7 = Normal

8-10 = Borderline abnormal (borderline case)

11-21 = Abnormal (case)

Geriatric Depression Scale (short form)

Instructions: Circle the answer that best describes how you felt over the past week.

1.	Are you basically satisfied with your life?	yes	no
2.	Have you dropped many of your activities and interests?	yes	no
3.	Do you feel that your life is empty?	yes	no
4.	Do you often get bored?	yes	no
5.	Are you in good spirits most of the time?	yes	no
6.	Are you afraid that something bad is going to happen to you?	yes	no
7.	Do you feel happy most of the time?	yes	no
8.	Do you often feel helpless?	yes	no
9.	Do you prefer to stay at home, rather than going out and doing things?	yes	no
10.	Do you feel that you have more problems with memory than most?	yes	no
11.	Do you think it is wonderful to be alive now?	yes	no
12.	Do you feel worthless the way you are now?	yes	no
13.	Do you feel full of energy?	yes	no
14.	Do you feel that your situation is hopeless?	yes	no
15.	Do you think that most people are better off than you are?	yes	no

Total Score _____

Geriatric Depression Scale (GDS)
Scoring Instructions

Instructions: Score 1 point for each bolded answer. A score of 5 or more suggests depression.

1.	Are you basically satisfied with your life?	yes	**no**
2.	Have you dropped many of your activities and interests?	**yes**	no
3.	Do you feel that your life is empty?	**yes**	no
4.	Do you often get bored?	**yes**	no
5.	Are you in good spirits most of the time?	yes	**no**
6.	Are you afraid that something bad is going to happen to you?	**yes**	no
7.	Do you feel happy most of the time?	yes	**no**
8.	Do you often feel helpless?	**yes**	no
9.	Do you prefer to stay at home, rather than going out and doing things?	**yes**	no
10.	Do you feel that you have more problems with memory than most?	**yes**	no
11.	Do you think it is wonderful to be alive now?	yes	**no**
12.	Do you feel worthless the way you are now?	**yes**	no
13.	Do you feel full of energy?	yes	**no**
14.	Do you feel that your situation is hopeless?	**yes**	no
15.	Do you think that most people are better off than you are?	**yes**	no

A score of $\geq$ 5 suggests depression ***Total Score*** _____

Ref. Yes average: The use of Rating Depression Series in the Elderly, in Poon (ed.): Clinical Memory Assessment of Older Adults, American Psychological Association, 1986

DRUG USE QUESTIONNAIRE (DAST-20)

Name: _____ Date: _____

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

For information on the DAST, contact Dr. Harvey Skinner at the Addiction Research Foundation, 33 Russell St., Toronto, Canada, M5S 2S1.

These questions refer to the past 12 months.

Circle your response

1. Have you used drugs other than those required for medical reasons?..... Yes No
2. Have you abused prescription drugs? ..... Yes No
3. Do you abuse more than one drug at a time? ..... Yes No
4. Can you get through the week without using drugs? ..... Yes No
5. Are you always able to stop using drugs when you want to?..... Yes No
6. Have you had "blackouts" or "flashbacks" as a result of drug use? ..... Yes No
7. Do you ever feel bad or guilty about your drug use? ..... Yes No
8. Does your spouse (or parents) ever complain about your involvement with drugs? ..... Yes No
9. Has drug abuse created problems between you and your spouse or your parents? ..... Yes No
10. Have you lost friends because of your use of drugs? ..... Yes No
11. Have you neglected your family because of your use of drugs? ..... Yes No
12. Have you been in trouble at work because of drug abuse? ..... Yes No
13. Have you lost a job because of drug abuse? ..... Yes No
14. Have you gotten into fights when under the influence of drugs? ..... Yes No
15. Have you engaged in illegal activities in order to obtain drugs? ..... Yes No
16. Have you been arrested for possession of illegal drugs? ..... Yes No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? ..... Yes No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?..... Yes No
19. Have you gone to anyone for help for a drug problem? ..... Yes No
20. Have you been involved in a treatment program specifically related to drug use? ..... Yes No

Hepatitis Risk Assessment Tool

"Hepatitis" means inflammation of the liver and is usually caused by a virus. In the U.S., the most common types are Hepatitis A, Hepatitis B, and Hepatitis C. Millions of Americans are living with viral hepatitis but most do not know they are infected. People can live with chronic hepatitis for decades without having symptoms.

This assessment will help determine if you should be vaccinated and/or tested for viral hepatitis by asking a series of questions. Depending on your answers, you will be given a tailored recommendation that you should discuss with your doctor or your professional healthcare provider. Any information received through the use of this tool is not medical advice and should not be treated as such.

Questions	Recommendations & Explanation
1. Have you ever been diagnosed with a clotting factor disorder?	If yes, talk to your doctor about getting vaccinated for Hepatitis A.
2. Have you ever been diagnosed with a chronic liver disease?	If yes, talk to your doctor about getting vaccinated for Hepatitis A and B.
3. Were you or at least one parent born outside of the United States?	If yes, talk to a doctor about getting a blood test for Hepatitis B. Many parts of the world have high rates of hepatitis B, including the Amazon Basin, parts of Asia, Sub-Saharan Africa and the Pacific Islands.
4. Do you currently live with someone who is diagnosed with Hepatitis B?	If yes, talk to a doctor about getting a blood test for Hepatitis B.
5. Have you previously lived with someone who has been diagnosed with hepatitis B?	If yes, talk to a doctor about getting a blood test for hepatitis B.
6. Have you recently been diagnosed with a sexually transmitted disease (STD)?	If yes, talk to a doctor about getting vaccinated for Hepatitis B.
7. Have you been diagnosed with diabetes?	If yes, talk to a doctor about getting vaccinated for Hepatitis B.
8. Have you been diagnosed with HIV/AIDS?	If yes, talk to a doctor about getting vaccinated for Hepatitis B and getting a blood test for Hepatitis B and Hepatitis C.
9. If you are a man, do you have sexual encounters with other men?	If yes, talk to a doctor about getting vaccinated for Hepatitis A and B, and getting a blood test for Hepatitis B.
10. Do you currently inject drugs?	If yes, talk to a doctor about getting vaccinated for Hepatitis A and B, and getting a blood test for Hepatitis B and C.
11. Were you born from 1945-1965?	If yes, talk to a doctor about getting a blood test for Hepatitis C
12. Have you ever received a blood transfusion or organ transplant before July 1992?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
13. Have you ever received a clotting factor concentrate before 1987?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
14. Have you ever injected drugs, even if just once?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
15. Do you plan on traveling outside of the United States within the next year?	If yes, talk to a doctor about what vaccines may be needed for travel outside the U.S.

California Adult Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic **adults** for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
- Do not treat for LTBI until active TB disease has been excluded:
  For patients with TB symptoms or an abnormal chest x-ray consistent with active TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

LTBI testing is recommended if any of the boxes below are checked.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥2 years old

☐ **Immunosuppression,** current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is ruled out.

☐ **None**; no TB testing is indicated at this time.

Provider Name: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

See the California Adult Tuberculosis Risk Assessment User Guide for more information about using this tool. To ensure you have the most current version, go to the TB RISK ASSESSMENT page (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Risk-Assessment.aspx)

California Adult TB Risk Assessment User Guide

Avoid testing persons at low risk

Routine testing of persons without risk factors is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Prioritize persons with risks for progression

If health system resources do not allow for testing of all non-U.S. born persons from a country with an elevated TB rate, prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within past 1 year
- end stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- body mass index ≤20
- History of chest x-ray findings suggestive of previous or inactive TB (no prior treatment). Includes fibrosis or non-calcified nodules, but does not include solitary calcified nodule or isolated pleural thickening. In addition to LTBI testing, evaluate for active TB disease.

United States Preventive Services Task Force

The USPSTF has recommended testing persons born in or former residents of, a country with an elevated tuberculosis rate and persons who live in or have lived in high-risk congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. The USPSTF did not review data supporting testing among close contacts to persons with infectious TB or among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

Children

This risk assessment tool is intended for adults. A risk assessment tool created for use in California for children is available on the TBCB Risk Assessment page. (https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-Pediatric-TB-Risk-Assessment.pdf)

Local recommendations

Local recommendations and mandates should also be considered in testing decisions. Local TB control programs can customize this risk assessment according to local recommendations. **Providers should check with local TB control programs for local recommendations.** A directory of TB Control Programs is available on the CTCA website. (https://www.ctca.org/locations.html)

Mandated testing and other risk factors

Several risk factors for TB that have been used to select patients for TB screening historically or in mandated programs are not included among the components of this risk assessment. This is purposeful in order to focus testing on patients at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Examples of these populations include: healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others.

Age as a factor

Age (among adults) is not considered in this risk assessment. However, younger adults have more years of expected life during which progression from latent infection to active TB disease could develop. Some programs or clinicians may additionally prioritize testing of younger non-U.S.-born persons when all non-U.S.-born are not tested. An upper age limit for testing has not been established but could be appropriate depending on individual patient TB risks, comorbidities, and life expectancy.

Foreign travel

Travel to countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with persons with infectious TB, high prevalence of TB in travel location, non-tourist travel). The duration of at least 1 consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after return from travel.

When to repeat a test

Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment. In general, this would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel in certain circumstances.

When to repeat a risk assessment

The risk assessment should be administered at least once. Persons can be screened for new risk factors at subsequent preventive health visits.

IGRA preference in BCG vaccinated

Because IGRA has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the TST in these persons. Most persons born outside the United States have been vaccinated with BCG.

Previous or inactive tuberculosis

Chest radiograph findings consistent with previous or inactive TB include fibrosis or non-calcified nodules, but do not include a solitary calcified nodule or isolated pleural thickening. Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI. In addition to LTBI testing, evaluate for active TB disease.

Negative test for LTBI does not rule out active TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. In fact, a negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease and poor outcome.

Symptoms that should trigger evaluation for active TB disease

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, and hemoptysis.

How to evaluate for active TB disease

Evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease

Most patients with LTBI should be treated

Persons with risk factors who test positive for LTBI should generally be treated once active TB disease has been ruled out. However, clinicians should not feel compelled to treat persons who have no risk factors but have a positive test for LTBI.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating latent TB infection have been shown to be as effective as 9 months of isoniazid, and are more likely to be completed. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are typical reasons these regimens cannot be used.

Shorter duration LTBI treatment regimens

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine	Weekly	12 weeks*

* 11-12 doses in 16 weeks required for completion.

Patient refusal of recommended LTBI treatment

Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded and CXR repeated if it has been more than 6 months from the initial evaluation; or more than 3 months if there is immunosuppression, or the prior CXR was abnormal and consistent with potentially active TB disease.

Resources

Fact Sheets for LTBI Regimens, Isoniazid+Rifapentine, Rifampin, and Isoniazid are available on the TBCB LTBI Treatment page. (www.cdph.ca.gov/LTBITreatment)

U.S. Preventive Services Task Force Latent TB Infection Screening Recommendations are available on the U.S. Preventive Services Task Force website. (https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening)

Abbreviations

AFB= acid-fast bacilli BCG= Bacillus Calmette-Guérin
CXR= chest x-ray DOT= directly observed therapy
IGRA=interferon gamma release assay LTBI= latent TB infection
MDR =multiple drug resistant NAAT= nucleic acid amplification testing
SAT= self-administered therapy TST= tuberculin skin test

Extended–Hurt, Insulted, Threaten, Scream (E-HITS)

Over the last 12 months, how often did your partner:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Frequently (5)
1. Physically hurt you?	❑	❑	❑	❑	❑
2. Insult your or talk down to you?	❑	❑	❑	❑	❑
3. Threaten you with harm?	❑	❑	❑	❑	❑
4. Scream or curse at you?	❑	❑	❑	❑	❑
5. Force you to have sexual activities?	❑	❑	❑	❑	❑

Score range: 5–25
Cutoff for IPV: ≥7

Iverson KM, King MW, Gerber MR, et al. Accuracy of an intimate partner violence screening tool for female VHA patients: a replication and extension. *J Trauma Stress*. 2015 Feb;28(1):79–82. doi: 10.1002/jts.21985 [doi]. PMID: 25624170. [PubMed] [CrossRef]

IPV Screening Tools

HITS

Hurt, Insult, Threaten, and Scream

How often does your partner physically **H**urt you?
How often does your partner **I**nsult or talk down to you?
How often does your partner **T**hreaten you with physical harm?
How often does you partner **S**cream or curse at you?

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Developer: Kevin Sherin, James Sinacore, Xiao-Qiang Li, Robert Zitter, and Amer Shakil

Publication year: 1998

Administration method: Self report or clinician administered.

Scoring procedures: Each question is answered on a 5-point scale:

1 = never, 2 = rarely, 3 = sometimes, 4 = fairly often, 5 = frequently

The scores range from 4 to a maximum of 20. For female patients, A HITS cut off score 10 or greater was used to classify participants as victimized; for male patients, A HITS cut off score of 11 or greater was used to classify participants as victimized (Sherin et al 1998; Shakil et al. 2005).

Follow-up procedures: This information is not available.

Index Reference:

Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. (1998). HITS: A short domestic violence screening tool for use in a family practice setting. *Family Medicine, 30*, 508-12.

Additional References:

Punukollu M (2003). Domestic violence: Screening made practical. *The Journal of Family Practice, 52*, 537-43.

3b. HARK questions*

H **HUMILIATION**

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?

A **AFRAID**

Within the last year, have you been afraid of your partner or ex-partner?

R **RAPE**

Within the last year have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?

K **KICK**

Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?

**screening questions developed in general practice Hardip Sohal (2011).*

Partner Violence Screen (PVS)

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?

2. Do you feel safe in your current relationship?

3. Is there a partner from a previous relationship who is making you feel unsafe now?

Reprinted with permission from Davis JW, Parks SN, Kaups KL, Bennink LD, Bilello JF. (2003). Victims of domestic violence on the trauma service: Unrecognized and underreported. *Journal of Trauma*, 54, 352-55.

Developer: Kim Feldhaus, Jane Koziol-McLain, Holly Amsbury, Ilena Norton, Steven Lowenstein, and Jean Abbott

Publication year: 1997

Administration method: Clinician administered.

Scoring procedures: Feldhaus et al. (1997) report the following:

> A "yes" response to the physical violence question was considered positive for partner violence if the perpetrator was a current or former spouse or other intimate partner. For the safety questions, women who reported feeling unsafe because of a current or past partner and those who were unsure about their safety were considered positive for partner violence...A positive response to any 1 of the 3 questions constitutes a positive screen for partner violence.

Follow-up procedures: All positive screens should be documented in the medical record, and the patient should be offered support, counseling, and referrals to safe shelters. A plan to ensure their future safety should be created (Feldhaus et al. 1997).

Index Reference:

Feldhaus KM, Koziol-McLain J, Amsbury HL, Norton IM, Lowenstein SR., Abbot JT. (1997). Accuracy of 3 brief screening questions for detecting partner violence in the emergency department. *Journal of the American Medical Association*, 277, 1357-61.

Additional References:

Davis JW, Parks SN, Kaups KL, Bennink LD, Bilello JF. (2003). Victims of domestic violence on the trauma service: Unrecognized and underreported. *Journal of Trauma*, 54, 352-55.

Woman Abuse Screening Tool (WAST)

1. In general, how would you describe your relationship?
   - ☐ A lot of tension
   - ☐ Some tension
   - ☐ No tension
2. Do you and your partner work out arguments with:
   - ☐ Great difficulty?
   - ☐ Some difficulty?
   - ☐ No difficulty?
3. Do arguments ever result in you feeling down or bad about yourse1f?
   - ☐ Often
   - ☐ Sometimes
   - ☐ Never
4. Do arguments ever result in hitting, kicking or pushing?
   - ☐ Often
   - ☐ Sometimes
   - ☐ Never
5. Do you ever feel frightened by what your partner says or does?
   - ☐ Often
   - ☐ Sometimes
   - ☐ Never
6. Has your partner ever abused you physically?
   - ☐ Often
   - ☐ Sometimes
   - ☐ Never
7. Has your partner ever abused you emotionally?
   - ☐ Often
   - ☐ Sometimes
   - ☐ Never
8. Has your partner ever abused you sexually?
   - ☐ Often
   - ☐ Sometimes
   - ☐ Never