BDI®—PC

Raw Score	Range of Severity
0-3	MINIMAL symptoms of depression reported
4-6	MILD symptoms of depression reported
7-9	MODERATE symptoms of depression reported
10-21	SEVERE symptoms of depression reported

It is recommended that the physician review item #6 in particular, as it concerns suicidal thoughts and wishes endorsed by the patient.

PATIENT SELF-EVALUATION

Patient's name: Date:

Instructions: This questionnaire consists of seven groups of statements. Read each group of statements carefully, then pick out the **one statement** in each group that best describes the way you have been feeling during the **past 2 weeks, including today**. Circle the number beside the statement you have picked. If several statements in one group seem to apply equally well, choose the statement with the highest number beside it.

1	**Sadness**	I do not feel sad	0
		I feel sad much of the time	1
		I am sad all the time	2
		I am so sad or unhappy that I can't stand it	3
2	**Pessimism**	I am not discouraged about my future	0
		I feel more discouraged about my future than I used to be	1
		I do not expect things to work out for me	2
		I feel my future is hopeless and will only get worse	3
3	**Past Failure**	I do not feel like a failure	0
		I have failed more than I should have	1
		As I look back, I see a lot of failures	2
		I feel I am a total failure as a person	3
4	**Self-Dislike**	I feel the same about myself as ever	0
		I have lost confidence in myself	1
		I am disappointed in myself	2
		I dislike myself	3
5	**Self-Criticalness**	I don't criticize or blame myself more than usual	0
		I am more critical of myself than I used to be	1
		I criticize myself for all of my faults	2
		I blame myself for everything bad that happens	3
6	**Suicidal Thoughts or Wishes**	I don't have any thoughts of killing myself	0
		I have thoughts of killing myself, but I would not carry them out	1
		I would like to kill myself	2
		I would kill myself if I had the chance	3
7	**Loss of Interest**	I have not lost interest in other people or activities	0
		I am less interested in other people or things than before	1
		I have lost most of my interest in other people or things	2
		It's hard to get interested in anything	3

Total Score:

Burns Anxiety Inventory

Rate all of the following symptoms with a number from 0-3

0 = Not at all
1 = Somewhat
2 = Moderately
3 = A lot

Total Score of
0-4 Indicates Minimal or no anxiety
5-10 Indicates Borderline anxiety
11-20 Indicates Mild anxiety
21-30 Indicates Moderate Anxiety
31-50 Indicate Severe Anxiety
51-99 Indicates Extreme Anxiety or Panic

Category I: Anxious Feelings

- ☐ Anxiety, nervousness, worry or fear
- ☐ Feeling that things around you are strange, unreal or foggy
- ☐ Feeling detached from all or part of your body
- ☐ Sudden unexpected panic spells
- ☐ Apprehension or a sense of impending doom
- ☐ Feeling tense, stressed, "uptight" or on edge

Category II: Anxious Thoughts

- ☐ Difficulty concentrating
- ☐ Racing thoughts or having your mind jump from one thing to the next
- ☐ Frightening fantasies or daydreams
- ☐ Feeling that you're on the verge of losing control
- ☐ Fears of cracking up or going crazy
- ☐ Fears of fainting or passing out
- ☐ Fears of physical illness or heart attacks or dying
- ☐ Concerns about looking foolish or inadequate in front of others
- ☐ Fears of being alone, isolated, or abandoned
- ☐ Fears of criticism
- ☐ Fears that something terrible is about to happen

Category III: Physical Symptoms

- ☐ Skipping or racing or pounding of the heart (sometimes called palpitations)
- ☐ Pain, pressure, or tightness in the chest
- ☐ Tingling of numbness in the toes or fingers
- ☐ Butterflies or discomfort in the stomach
- ☐ Constipation or diarrhea
- ☐ Restlessness or jumpiness
- ☐ Tight, tense muscles
- ☐ Sweating not brought on by heat
- ☐ A lump in the throat
- ☐ Trembling or shaking
- ☐ Rubbery or "jelly" legs
- ☐ Feeling dizzy, lightheaded, or off balance
- ☐ Choking or smothering sensations or difficult
- ☐ Headaches or pains in the neck or back
- ☐ Hot flashes or cold chills
- ☐ Feeling tired, weak or easily exhausted

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Brief Mood Survey

Full Name _____ DOB_____ Date _____

Instructions: Put a √ after each item to indicate how you have been feeling. **Please answer all items.** Please rate your feelings for the last 24 hours only.

Diagnosis: _____ **Problem:** _____ **Problem:** _____	0 – Not at All	1 – Somewhat	2 – Moderately	3 – A Lot	4 – Extremely
DEPRESSION					
1. Sad or down in the dumps					
2. Discouraged or hopeless					
3. Low self-esteem					
4. Worthlessness or inadequate					
5. Loss of pleasure or satisfaction in life					
	Please total your score on lines 1 thru 5 here →				
ANXIETY					
1. Anxious					
2. Frightened					
3. Worrying about things over and over					
4. Tense or on edge					
5. Nervous					
	Please total your score on lines 1 thru 5 here →				
PANIC					
1. Sudden feelings of terror or overwhelming fear					
2. Sudden, terrifying panic attacks that come out of the blue					
3. Suddenly feeling you are going crazy or cracking up					
4. Suddenly feeling you are about to suffocate or pass out					
5. Suddenly feeling you'll have a stroke, heart attack, or die					
	Please total your score on lines 1 thru 5 here →				
ANGER					
1. Frustrated					
2. Annoyed					
3. Resentful					
4. Angry					
5. Irritated					
	Please total your score on lines 1 thru 5 here →				
SUICIDAL URGES					
1. Do you have any suicidal thoughts?					
2. Would you like to end your life?					
	Please total your score on lines 1 thru 2 here →				

LEVEL 2—Substance Use—Adult*

*Adapted from the NIDA-Modified ASSIST

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "using medicines on your own without a doctor's prescription, or in greater amounts or longer than prescribed, and/or using drugs like marijuana, cocaine or crack, and/or other drugs" at a slight or greater level of severity. The questions below ask how often you (the individual receiving care) have used these medicines and/or substances **during the past 2 weeks.** **Please respond to each item by marking (✓ or x) one box per row.**

During the past **TWO (2) WEEKS**, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed?							**Clinician Use**
		Not at all	**One or two days**	**Several days**	**More than half the days**	**Nearly every day**	**Item Score**
a.	Painkillers (like Vicodin)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
b.	Stimulants (like Ritalin, Adderall)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
c.	Sedatives or tranquilizers (like sleeping pills or Valium)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
Or drugs like:							
d.	Marijuana	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
e.	Cocaine or crack	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
f.	Club drugs (like ecstasy)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
g.	Hallucinogens (like LSD)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
h.	Heroin	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
i.	Inhalants or solvents (like glue)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
j.	Methamphetamine (like speed)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Total Score:	