NATIONAL DEPRESSION SCREENING DAY® – ADULT SCREENING FORM

1) Age: _____

2) Sex: _____ (M/F)

3) Current Marital Status:

☐ Divorced / Separated ☐ Never Married
☐ Living with Partner ☐ Widowed
☐ Married

4) Ethnic / Racial Group:

☐ African American ☐ Caucasian
☐ American Indian ☐ Hispanic
☐ Asian American ☐ Other

5) Have you ever been treated for:
(Check all that apply)

	Yes	No
Depression	☐	☐
Bipolar Disorder	☐	☐
Generalized Anxiety Disorder	☐	☐
Post-Traumatic Stress Disorder	☐	☐

If yes:
Did treatment include medication ☐ ☐

6) Have you ever been treated for:
(Check all that apply)

☐ Alcohol Abuse ☐ HIV
☐ Cancer ☐ Seizure Disorder
☐ Chronic Pain ☐ Thyroid Problem
☐ Diabetes ☐ None of the above
☐ Drug Abuse
☐ Heart Disease / Stroke

Participant No.

	Yes	No
7) Have you ever attempted suicide:	☐	☐

THE HANDS® DEPRESSION SCREENING TOOL (The Harvard Department of Psychiatry / National Depression Screening Day® Scale)

■ **Over the <u>past two weeks</u>, how often have you:**	**None or little of the time**	**Some of the time**	**Most of the time**	**All of the time**	Staff Use Only
1. been feeling low in energy, slowed down?					
2. been blaming yourself for things?					
3. had poor appetite?					
4. had difficulty falling asleep, staying asleep?					
5. been feeling hopeless about the future?					
6. been feeling blue?					
7. been feeling no interest in things?					
8. had feelings of worthlessness?					
9. thought about or wanted to commit suicide?					
10. had difficulty concentrating or making decisions?					
				Total Score:	

THE MOOD DISORDER QUESTIONNAIRE

■ **Please answer each question as best you can.**	**YES**	**NO**	Staff Use Only
1. Has there ever been a period of time when you were not your usual self and...			
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐	
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐	
...felt much more self-confident than usual?	☐	☐	
...you got much less sleep than usual and found you didn't really miss it?	☐	☐	
...you were much more talkative or spoke much faster than usual?	☐	☐	
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐	
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐	
...you had much more energy than usual?	☐	☐	
...you were much more active or did many more things than usual?	☐	☐	
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐	
...you were much more interested in sex than usual?	☐	☐	
...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	☐	☐	
...spending money got you or your family into trouble?	☐	☐	
	Total Score:		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐	
3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please check **(✓) one response only.** ☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem			

See reverse for additional screening tools

CLINICIAN: FILL OUT SCREENING RECOMMENDATION SECTION (See box on reverse side)

CARROLL-DAVIDSON GENERALIZED ANXIETY DISORDER SCREEN©

■ **These questions are to ask about things you may have felt most days in the <u>past six months</u>.**	**YES**	**NO**	Staff Use Only
1. Most days I feel very nervous.	☐	☐	
2. Most days I worry about lots of things.	☐	☐	
3. Most days I cannot stop worrying.	☐	☐	
4. Most days my worry is hard to control.	☐	☐	
5. I feel restless, keyed up or on edge.	☐	☐	
6. I get tired easily.	☐	☐	
7. I have trouble concentrating.	☐	☐	
8. I am easily annoyed or irritated.	☐	☐	
9. My muscles are tense and tight.	☐	☐	
10. I have trouble sleeping.	☐	☐	
11. Did the things you noted above affect your daily life (home life, or work, or leisure) or cause you a lot of distress?	☐	☐	
12. Were the things you noted above bad enough that you thought about getting help for them?	☐	☐	

Total Score:

MODIFIED SPRINT (SPRINT-4©) PTSD SCREEN

If at any time you have experienced or witnessed a traumatic event, which involves loss of life, serious injury or threat of either: ■ **Please respond to these questions about how you have felt most days in the <u>past week</u>.**	**YES**	**NO**	Staff Use Only
1. Have you been bothered by unwanted memories, nightmares, or reminders of this event?	☐	☐	
2. Have you been making an effort to avoid thinking or talking about this event, or doing things which remind you of what happened?	☐	☐	
3. Have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings?	☐	☐	
4. Have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you?	☐	☐	

Total Score:

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

PLEASE RETURN THIS FORM TO STAFF FOR SCORING.

SCREENING RECOMMENDATION (TO BE FILLED OUT BY CLINICIAN ONLY)

■ **I spoke with the participant and recommended: (Check all that apply)**

Follow-up for:
☐ Depression ☐ Bipolar Disorder ☐ No follow-up needed
☐ Generalized Anxiety Disorder ☐ Post-Traumatic Stress Disorder

■ **If a Community-Based Site:**
- ☐ Outpatient Referral
- ☐ Inpatient Referral
  - ☐ Voluntary
  - ☐ Emergency

■ **If a Primary Care Facility:**
- ☐ Treated in office
- ☐ Referred Elsewhere
- ☐ Emergency