HEALTH SCREEN

Please circle or check your response:

A. Over the past 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

	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?	☐	☐

*Drugs refer to illegal drugs and prescription drugs.

In the last month have you had thoughts that you would be better off dead or hurting yourself?	☐	☐

Office Staff:
Score: ____________

Signature: __________________________________ Date: __________________

RIVERSIDE COUNTY HEALTH SYSTEM
DIVISION OF AMBULATORY CARE