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?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**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