Last Name _____
Last Four _____

Please return to _____

PRE HEPATITIS-C TREATMENT
LIVER CLINIC

Behavioral Health Screening

GAD-7

Over the last two weeks, how often have you been bothered by the following:	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to sleep or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

PC-PTSD

Have you ever had *any* experience that was so frightening, horrible, or upsetting that in the PAST MONTH you:

Y N Have had any nightmares about it, or thought about it when you did not want to?

Y N Tried hard not to think about it, or went out of your way to avoid situations that remind you of it?

Y N Were constantly on guard, watchful, or easily startled?

Y N Felt numb or detached from others, activities, or your surroundings?

PHQ-9

Over the *last 2 weeks*, how often have you been bothered by any of the following:	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 asleep, 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
10. If you checked off any of the above 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

AUDIT-C

1) How often have you had a drink containing alcohol in the past year?

0 – Never
1 – Monthly or less
2 – Two to four times per month
3 – Two to four times per week
4 – Four or more times per week

2) How many drinks did you have on a typical day when you were drinking in the past year?

0 – 0 drinks
1 – 1 or 2
2 – 3 or 4
3 – 5 or 6
4 – 7 to 9
5 – 10 or more

3) How often did you have 6 or more drinks on one occasion in the past year?

0 – Never
1 – Less than monthly
2 – Monthly
3 – Weekly
4 – Daily or almost daily

<u>If you sought mental health services during your treatment for Hepatitis C</u>, how would you respond to the following questions? Please use the scale below.

1	2	3	4	5
Strongly Disagree		*Agree and Disagree Equally*		*Strongly Agree*

1. _____I would feel inadequate if I went to a therapist for psychological help.

2. _____Seeking psychological help would make me feel less intelligent.

3. _____It would make me feel inferior to ask a therapist for help.

4. _____If I went to a therapist, I would be less satisfied with myself.

5. _____I would feel worse about myself if I could not solve my own problems.

This questionnaire is made up of a list of statements each of which may or may not be true about you. In general, rate how true or false each statement is.

1	2	3	4	5
Strongly Disagree		*Agree and Disagree Equally*		*Strongly Agree*

1. _____I feel that there is no one I can share my most private worries and fears with.

2. _____If I were sick, I could easily find someone to help me with my daily chores.

3. _____There is someone I can turn to for advice about handling problems with my friends or family.

4. _____If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.

5. _____When I need suggestions on how to deal with a personal problem, I know someone I can turn to.

6. _____I don't often get invited to do things with others.

7. _____If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.

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1. Do you have a history of any emotional problems? ___Yes ___No

   A. If yes, check all that apply:

   ___Depression ___Bipolar Disorder (manic-depressive)
   ___Anxiety (nerves) ___Post-traumatic stress disorder (PTSD)
   ___Schizophrenia ___Other:_____

   B. Have you ever been hospitalized for emotional reasons? ___Yes ___No

2. Are you currently being treated for any emotional problems? ___Yes ___No

   If yes, what problems? _____
   Who treats you? _____
   Where do you receive treatment? _____

3. Have you ever seen or heard things that no one else can (hallucinate)?

   ___ Never ___In the Past ___Currently

4. Have you ever had thoughts of hurting or killing yourself?

   ___ Never ___In the Past ___Currently

5. Have you ever had thoughts of hurting or killing someone else?

   ___ Never ___In the Past ___Currently

6. Have you ever hit your head so hard you lost consciousness?
___Yes ___No Date(s) _____

7. In the last six months, have you talked with your provider about any problems with memory or attention?
___Yes ___No
If yes, what did you tell them? _____

8. In the past six months, did you ever have any difficulty managing your day-to-day finances?
___Yes ___No ___Occasionally ___ I am no longer able to do this on my own

9. In the past six months, did you ever have any difficulty keeping up with your mail?
___Yes ___No ___Occasionally ___ I am no longer able to do this on my own

10. Do you use my Health-e Vet? ___Yes ___No

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1. What drugs have you EVER used in your LIFETIME? (check all that apply)
___Marijuana/hashish ___Cocaine ___Methamphetamine/Speed

___Heroin ___LSD/PCP ___Ecstasy

___Other: please specify_____None

2. What drugs have you used in the LAST 6 MONTHS? (check all that apply)
___Marijuana/hashish ___Cocaine ___Methamphetamine/Speed

___Heroin ___LSD/PCP ___Ecstasy

___Other: please specify_____None

3. Have you ever injected any drugs, even once? ___Yes ___No
If yes, year last used:_____

4. Have you ever had drug or alcohol treatment? ___Yes ___No
If yes, how many times?_____
Last year treated?_____

5. Have you ever used prescription drugs, such as painkillers or sedatives, for RECREATIONAL or social purposes?

___Never ___In the past ___Currently