Patient Well-Being Screener

Name: ______________________________

Person completing form: ______________________

Birthdate: __________ Today's Date: __________

Peak Vista is committed to treating the whole person. As part of your care team, we want help with all aspects of your health. Please respond to the following questions to let us know how you are doing.

Over the ***last two weeks***, how often have you been bothered by any of the following problems? (please circle the choice that apply to you)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let your family down	0	1	2	3
Trouble concentrating on things such as reading the newspaper or watching tv	0	1	2	3
Moving or speaking so slowly that other people could notice, OR so fidgety or restless that you have been moving around more than usual	0	1	2	3
Thoughts that you would be better off dead, OR thoughts of hurting yourself in some way	0	1	2	3
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worry	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

If you checked off any 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? *(Please circle your selection from the choices below.)*

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Continue on back side ➡

Are you currently in any physical pain?	No	Yes	Rating ___ / 10

(10 = worst pain imaginable)

In your life, have you ever had an experience that was so frightening, horrible, or traumatic that, ***in the past month***, you:

Have had nightmares about it or thought about it when you did not want to?	No	Yes
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	No	Yes
Were constantly on guard, watchful, or easily startled?	No	Yes
Felt numb or detached from others, activities, or your surroundings?	No	Yes
Felt guilty or unable to stop blaming yourself or others for it or nay problems it may have caused?	No	Yes

Drinking alcohol and using drugs can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by these activities.

Standard serving of one drink:

- 12 ounces of beer or wine cooler
- 1.5 ounces of 80 proof liquor
- 5 ounces of wine
- 4 ounces of brandy, liqueur, or aperitif

*If you are **18y or older**, please answer the following questions:*

How many times in the past year have you had 3 or more drinks in a day?	None	1 or more
How many times in the past year, have you used a recreational drug or used prescription medication for nonmedical reasons?	None	2 or more

*If you are **12y-17y**, please answer the following questions:*

Drink more than a few sips of beer, wine, or any drink containing alcohol?	None	1 or more
Use any marijuana (weed, oil, or hash by smoking, vaping, or in food) or synthetic marijuana (like "K2", "Spice") or vaping THC oil?	None	1 or more
Use anything else to get high (like illegal drugs, prescription or over-the-counter medications, and things you sniff, huff, or vape)?	None	1 or more
Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	No	Yes
Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	No	Yes
Do you ever use alcohol or drugs while you are by yourself, or ALONE?	No	Yes

If you have any questions, please ask your provider. Thank you!