Patient Stress Questionnaire*

Name: _____

Date:_____ **Birthdate**_____

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

	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 or 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've been moving around a lot more than usual	0	1	**2**	**3**	
9. ☐ Thoughts that you would be better off dead, or ☐ hurting yourself in some way	0	**1**	**2**	**3**	**Total**
(10)		add columns:			

1. Feeling nervous, anxious or on edge	0	1	**2**	**3**	
2. Not being able to stop 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**	**Total**
(8)		add columns:			

*adapted from PhQ 9, GAD7, PC-PTSD and AUDIT 1/24/11

Please also complete back side →

Provider:_____

Are you currently in any physical pain?	No	Yes

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

1. Have had nightmares about it or thought about it when you did not want to?	No	Yes
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	No	Yes
3. Were constantly on guard, watchful, or easily startled?	No	Yes
4. Felt numb or detached from others, activities, or your surroundings?	No	Yes

(3)

Drinking alcohol 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 drinking.

These questions are about your drinking habits. We've listed the serving size of one drink below.

Please circle your answer	0	1	2	3	4
How often do you have one drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times per week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the ***last year*** have you……					
…found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…needed a first drink in the morning to get yourself going after heavy drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	0		2		4
Have you or someone else been injured as a result of your drinking?	No	Yes, but not in the last year			Yes, during the last year
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year			Yes, during the last year

(8)

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

Total: