

Pinnacle Health Services Screening Questionnaire*

Name: _____

In order to help you move forward in the direction you would like to be going in your life, we would appreciate learning more about what problems or difficulties you might be experiencing as well as what you would like to see change in your life.

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. <input type="checkbox"/> Trouble falling or staying asleep, or <input type="checkbox"/> sleeping too much	0	1	2	3	
4. Feeling tired or having little energy	0	1	2	3	
5. <input type="checkbox"/> Poor appetite or <input type="checkbox"/> 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. <input type="checkbox"/> Moving or speaking so slowly that other people could have noticed, or <input type="checkbox"/> the opposite - being so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3	
9. <input type="checkbox"/> Thoughts that you would be better off dead, or <input type="checkbox"/> 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 →

Are you currently in any physical pain?	No	Yes
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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



What are the top 1-3 things you would like to see change in your life right now?

1. _____
2. _____
3. _____

What are the most important reasons why you want to make the changes above?

What goals would you like to work on with a counselor/therapist, if any?

Thank you for taking the time to complete this questionnaire. We look forward to working with you on your goals!