

VTC Health Self-Screener Packet

This packet includes several validated screening tools for identifying symptoms of depression, anxiety, PTSD, substance use, and alcohol use. These self-report questionnaires are designed for screening purposes only and should not replace professional evaluation or diagnosis. All information provided on this mental health screening questionnaire is confidential. Responses will be reviewed only by authorized members of the Behavioral Health team and will be used solely for clinical evaluation and care purposes.

PHQ-9: Patient Health Questionnaire

Over the last 2 weeks, how often have you been bothered by the following problems?

Question	Response
1. Little interest or pleasure in doing things	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
2. Feeling down, depressed, or hopeless	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
3. Trouble falling or staying asleep, or sleeping too much	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
4. Feeling tired or having little energy	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
5. Poor appetite or overeating	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
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 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

Scoring: Add up the responses. 0–4 = Minimal, 5–9 = Mild, 10–14 = Moderate, 15–19 = Moderately Severe, 20–27 = Severe Depression.

GAD-7: Generalized Anxiety Disorder Scale

Over the last 2 weeks, how often have you been bothered by the following problems?

Question	Response
1. Feeling nervous, anxious, or on edge	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
2. Not being able to stop or control worrying	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
3. Worrying too much about different things	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
4. Trouble relaxing	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
5. Being so restless that it's hard to sit still	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
6. Becoming easily annoyed or irritable	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
7. Feeling afraid as if something awful might happen	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

Scoring: Add up the responses. 0–4 = Minimal, 5–9 = Mild, 10–14 = Moderate, 15–21 = Severe Anxiety.

PCL-5: PTSD Checklist for DSM-5

Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each one carefully and select one of the options below.

Question	Response
1. Repeated, disturbing memories, thoughts, or images of the stressful experience?	0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely
2. Repeated, disturbing dreams of the stressful experience?	0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely
3. Suddenly feeling or acting as if the stressful experience were happening again (as if you were reliving it)?	0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely
4. Feeling very upset when something reminded you of the stressful experience?	0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely
5. Having strong physical reactions when something reminded you of the stressful experience (e.g., heart pounding, trouble breathing, sweating)?	0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely
7. Avoiding external reminders of the stressful experience (e.g., people, places, conversations, activities)?	0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely
8. Trouble remembering important parts of the stressful experience?	0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely
9. Having strong negative beliefs about yourself, other people, or the world?	0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely

- | | | | |
|---|------------------------------|-------------------------------------|----------------------|
| 12. Loss of interest in activities you used to enjoy? | 0 = Not at all
Moderately | 1 = A little bit
3 = Quite a bit | 2 =
4 = Extremely |
| 13. Feeling distant or cut off from other people? | 0 = Not at all
Moderately | 1 = A little bit
3 = Quite a bit | 2 =
4 = Extremely |
| 14. Trouble experiencing positive feelings (e.g., being unable to feel happiness or loving feelings)? | 0 = Not at all
Moderately | 1 = A little bit
3 = Quite a bit | 2 =
4 = Extremely |
| 15. Irritable behavior, angry outbursts, or acting aggressively? | 0 = Not at all
Moderately | 1 = A little bit
3 = Quite a bit | 2 =
4 = Extremely |
| 16. Taking too many risks or doing things that could cause you harm? | 0 = Not at all
Moderately | 1 = A little bit
3 = Quite a bit | 2 =
4 = Extremely |
| 17. Being “superalert” or watchful or on guard? | 0 = Not at all
Moderately | 1 = A little bit
3 = Quite a bit | 2 =
4 = Extremely |
| 18. Feeling jumpy or easily startled? | 0 = Not at all
Moderately | 1 = A little bit
3 = Quite a bit | 2 =
4 = Extremely |
| 19. Having difficulty concentrating? | 0 = Not at all
Moderately | 1 = A little bit
3 = Quite a bit | 2 =
4 = Extremely |
| 20. Trouble falling or staying asleep? | 0 = Not at all
Moderately | 1 = A little bit
3 = Quite a bit | 2 =
4 = Extremely |

Scoring: Add up the responses (0–80). A score of 33 or higher may indicate probable PTSD.

DAST-10: Drug Abuse Screening Test

The following questions concern information about your possible involvement with drugs not including alcoholic beverages or tobacco. Please answer every question.

Question	Response
1. Have you used drugs other than those required for medical reasons?	Yes / No
2. Do you abuse more than one drug at a time?	Yes / No
3. Are you always able to stop using drugs when you want to?	Yes / No
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes / No
5. Do you ever feel bad or guilty about your drug use?	Yes / No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes / No
7. Have you neglected your family because of your use of drugs?	Yes / No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes / No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes / No
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes / No

Scoring: 1 point for each 'Yes' response. 0 = None, 1-2 = Low, 3-5 = Moderate, 6-8 = Substantial, 9-10 = Severe drug problems.

AUDIT-C: Alcohol Use Disorders Identification Test (Short Form)

Please answer the following questions about your alcohol use.

Question	Response
1. How often do you have a drink containing alcohol?	Q1: 0 = Never, 1 = Monthly or less, 2 = 2-4 times/month, 3 = 2-3 times/week, 4 = 4+ times/week Q2: 0 = 1-2, 1 = 3-4, 2 = 5-6, 3 = 7-9, 4 = 10+ Q3: 0 = Never, 1 = Less than monthly, 2 = Monthly, 3 = Weekly, 4 = Daily or almost daily
2. How many standard drinks containing alcohol do you have on a typical day?	Q1: 0 = Never, 1 = Monthly or less, 2 = 2-4 times/month, 3 = 2-3 times/week, 4 = 4+ times/week Q2: 0 = 1-2, 1 = 3-4, 2 = 5-6, 3 = 7-9, 4 = 10+ Q3: 0 = Never, 1 = Less than monthly, 2 = Monthly, 3 = Weekly, 4 = Daily or almost daily
3. How often do you have six or more drinks on one occasion?	Q1: 0 = Never, 1 = Monthly or less, 2 = 2-4 times/month, 3 = 2-3 times/week, 4 = 4+ times/week Q2: 0 = 1-2, 1 = 3-4, 2 = 5-6, 3 = 7-9, 4 = 10+ Q3: 0 = Never, 1 = Less than monthly, 2 = Monthly, 3 = Weekly, 4 = Daily or almost daily

Scoring: Add up responses (0-12). Men: ≥ 4 , Women: ≥ 3 indicates risky or hazardous drinking.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	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 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

FOR OFFICE CODING 0 + + +
=Total Score:

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?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult