Behavioral Health Questionnaire

Healthy Minds
Community Resources for Resilience, Support & Well-being

Name: ______________________________

Date:______________ **Birthdate/Age**____________

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 & CAGE-AID

C	Have you ever felt the need to **cut** down on your drinking or drug use?	No	Yes
A	Have people **annoyed** you by criticizing your drinking or drug use?	No	Yes
G	Have you ever felt **guilty** about drinking or drug use?	No	Yes
E	Have you ever felt you needed a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**Eye-Opener**)?	No	Yes

Would you like to receive a follow up from one of our team members within the next week? Yes __________

No __________

If yes, please provide your best phone number or email address. Phone: ____________________

Email address: ____________________________________

If by phone, may we leave a message in the event that you do not answer? Yes ______________

No ______________

Scores that are severe and/or life threatening are typically urgent referrals to BHS based on the following scores:

- PHQ-9: 0-4 = Mild 5-14 = Moderate 15+ = Severe
- GAD-7: 0-4 = Mild 5-14 = Moderate 15+ = Severe
- CAGE-AID: A "yes" answer to one item indicates a possible substance use disorder and a need for further testing.