Public Health
Tuscarawas County Health Department

TUSCARAWAS COUNTY
GENERAL HEALTH DISTRICT

Annual Questionnaire

Name: _____ Date of Birth: _____ ☐ Male ☐ Female Today's Date: _____

In order to provide you with the best health care and to reduce the risk of harmful prescription drug interaction, please answer the following questions concerning your use of alcohol and other drugs and your mood. Your answers will be kept confidential. Thank you for your cooperation.

Instructions: Please mark one response for each question.

One drink of alcohol = oz.	 12 oz.	or	 5 oz.	or	 1 ½
	Beer		Wine		Liquor (one shot)

1. FEMALES: How many **TIMES** in the past year have you had 3 or more drinks in a day?

☐ a. None **= 0** ☐ b. 1 or more **TIMES = 1**

1. MALES: How many **TIMES** in the past year have you had 4 or more drinks in a day?

☐ a. None **= 0** ☐ b. 1 or more **TIMES = 1**

(If "b" selected in either question, click here to complete the alcohol screening form.)

Alcohol Screening Form

In the past YEAR how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
(SCORING)	**0**	**1**	**1**	**1**	**1**
2. Prescription drugs other than how they were prescribed to you by your medical provider					
3. Recreational drugs					

(Score = 1, do full screen for drugs.)

Drug Screen Form

Over the past 2 WEEKS how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
(SCORING)	**0**	**1**	**2**	**3**
4. Little interest or pleasure in doing things				
5. Feeling down, depressed or hopeless				

(Score ≥ 3, do full screen for depression.) 0

Depression Screening Form

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Reference: Question 1 NIAAA; Questions 2-3 modified NIDA Quick Screen V1.0 adapted from Saitz et al.; Questions 4-5 PHQ-2

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Alcohol Screening Questionnaire (AUDIT)

Name: _____ Date of Birth: _____ □ Male □ Female Today's Date: _____

The results of the annual questionnaire for your alcohol use indicate that additional information is needed. Please answer the following questions to help improve your health outcomes. Your answers will be kept confidential. Thank you for your cooperation.

Instructions: Please enter a corresponding number from the top row in the right-hand column. Mark one response for each question. Be sure to complete both sides of the questionnaire.

One drink of alcohol = 

12 oz. Beer or  5 oz. Wine or  1 ½ oz. Liquor (one shot)

	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. 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	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. 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	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL	0

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Reprinted with permission from the World Health Organization. The number of drinks in question 3 was changed from 6 to 5 to reflect US serving sizes.
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Drug Screening Questionnaire (DAST)

Name: _____ Date of Birth: _____ □ Male □ Female Today's Date: _____

Drug Screening Questionnaire (DAST)

The results of the annual questionnaire for your drug use indicate that additional information is needed. Please answer the following questions to help improve your health outcomes. The questions do not include the use of alcohol or tobacco. Your answers will be kept confidential. Thank you for your cooperation.

Instructions: Please mark one response for each question.

These questions refer to the past 12 months:

1. Have you used drugs other than those required for medical reasons?	☐	☐
2. Do you abuse more than one drug at a time?	☐	☐
3. Are you always able to stop using drugs when you want to?	☐	☐
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	☐	☐
5. Do you ever feel bad or guilty about your drug use?	☐	☐
6. Does your spouse (or parents) ever complain about your involvement with drugs?	☐	☐
7. Have you neglected your family because of your use of drugs?	☐	☐
8. Have you engaged in illegal activities in order to obtain drugs?	☐	☐
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐	☐
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	☐	☐

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Patient Health Questionnaire (PHQ-9)

DEPRESSION

Name: _____ Date of Birth: _____ □ Male □ Female Today's Date: _____

The results of the annual questionnaire for your mood indicate that additional information is needed. Please answer the following questions to help improve your health outcomes. Your answers will be kept confidential. Thank you for your cooperation.

Instructions: Please mark one response for each statement.

Over the last 2 *WEEKS* how often have you been bothered by any of the following problems?	**Not at All**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
(SCORING)	**0**	**1**	**2**	**3**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless		0		
3. Trouble falling or staying asleep or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things such as reading the newspaper or watching television				
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				
9. Thoughts that you would be better off dead or of hurting yourself				
Add Columns		0 +	0 +	0
TOTAL		0		

10. *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

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