PATIENT FORM **Memory and Brain Wellness Clinic** PHQ-9, GAD-7 & Patient Concerns i.

Important: This form is to be filled out by the PATIENT. Please fill out both front and back. If the patient is unable to fill out this form, please leave it blank.

Over the last 2 weeks, how often have you been bothered by any of the following problems?			Several days	More than half the days	Nearly every day			
		(0)	(1)	(2)	(3)			
1	Little interest or pleasure in doing things							
2	Feeling down, depressed, or hopeless							
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 in some way							
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 (0) Somewhat difficult (1) Very difficult (2) Extremely difficult (3) Image: Comparison of the second								
PRO	VIDER SIGNATURE PRINT NAME PAGEF	R NPI		TIME D.	ATE			
	2HO-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer Japet B.W. Williams, Kurt Kroepke, and colleagues							

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Harborview Medical Center - University of Washington Medical Center UW Medicine Primary Care - Valley Medical Center - UW Physicians **M&BW PATIENT QUESTIONNAIRE**

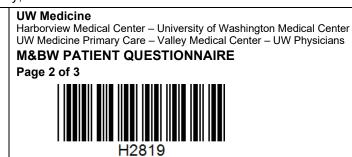


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be	ver the las teen bothere		-		Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)		
1	Feeling nerv	ous, anxiou	s or on edg	ge						
2	Not being at	ole to stop o	r control we	orrying						
3	Worrying too	much abou	ut different	things						
4	Trouble relat	xing								
5	Being so res	tless that it	is hard to s	sit still						
6	Becoming ea	asily annoye	ed or irritab	le						
7	Feeling afrai	d as if some	ething awfu	Il might h	appen					
	you checked Not difficult at	take c	are of thin		ome, or g	et along wil	ms made it for th other peop ifficult (2)	or you to do your work, le? Extremely difficult (3)		
Among the things listed below, what describes						your feeling	gs today (che	eck all that a	pply)?	
	I am cor	ncerned abo	out my men	nory.						
[_	ncerned abo	out my phys	sical hea	lth.					
	I am worried about my safety at home.									
	This clinic visit was the idea of somebody else. I am not sure I need or want to be here today.								-	
L	At today's visit, I want to talk about (please fill in any additional concerns not listed above):									
	his section	New	Return		Provider					
TII	filled by staff only			TG	KDR		DM KC			
Diagnosis #1 Diagno				Diagnos	is #2	Diagnosis #3				
Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.										

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PATIENT FORM Memory and Brain Wellness Clinic AUDIT

Important: This form is to be filled out by the PATIENT. If the patient is unable to fill out this form, please leave it blank.

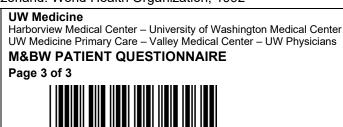
Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. (*Staff: add up score per item for the total*)

Fo	or each question	n, place ar			0	1	2	3	4
1	How often do y alcohol?	Never	Monthly or less	2–4 times a month	2–3 times a week	4 or more times a week			
2	How many drir on a typical da	1 or 2	3 or 4	5 or 6	7 to 9	10 or more			
3	How often do yoccasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
4	How often duri that you were 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?					Monthly	Weekly	Daily or almost daily
6	How often duri a first drink in t after a heavy o	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
7	How often duri feeling of guilt	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
8	unable to reme	How often during the last year have you been unable to remember what happened the night before because of your drinking?					Monthly	Weekly	Daily or almost daily
9	Have you or so of your drinkin	No		Yes, but not in the last year		Yes, during the last year			
10	Has a relative, worker been c suggested you	No		Yes, but not in the last year		Yes, during the last year			
	This section New Return filled by staff □ Provider: □TG □KDR □RK □SDM □KC □AH □EL □AMC only □ □							EL DAMC	

 PROVIDER SIGNATURE
 PRINT NAME
 PAGER
 NPI
 TIME
 DATE

 Babor, T.F.; de la Fuente, J.R.; Saunders, J.; and Grant, M. AUDIT. The Alcohol Use Disorders Identification Test.
 Date

Guidelines for use in primary health care. Geneva, Switzerland: World Health Organization, 1992



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