Name:_____ MR:_____ Date:____/____/____

Eating Attitudes Test (EAT-26)

The following screening questionnaire is designed to help you determine if your eating behaviors and attitudes warrant further evaluation. The questionnaire is **not intended to provide a diagnosis**. Rather, it identifies the presence of symptoms that are consistent with either a possible eating disorder.

Answer the questions as honestly as you can, and then score questions using the instructions at the end.

✓	**Please mark a check to the right of each of the following statements:**	Always	Usually	Often	Some times	Rarely	Never	Score
1.	Am terrified about being overweight.	_	_	_	_	_	_	
2.	Avoid eating when I am hungry.	_	_	_	_	_	_	
3.	Find myself preoccupied with food.	_	_	_	_	_	_	
4.	Have gone on eating binges where I feel that I may not be able to stop.	_	_	_	_	_	_	
5.	Cut my food into small pieces.	_	_	_	_	_	_	
6.	Aware of the calorie content of foods that I eat.	_	_	_	_	_	_	
7.	Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	_	_	_	_	_	_	
8.	Feel that others would prefer if I ate more.	_	_	_	_	_	_	
9.	Vomit after I have eaten.	_	_	_	_	_	_	
10.	Feel extremely guilty after eating.	_	_	_	_	_	_	
11.	Am preoccupied with a desire to be thinner.	_	_	_	_	_	_	
12.	Think about burning up calories when I exercise.	_	_	_	_	_	_	
13.	Other people think that I am too thin.	_	_	_	_	_	_	
14.	Am preoccupied with the thought of having fat on my body.	_	_	_	_	_	_	
15.	Take longer than others to eat my meals.	_	_	_	_	_	_	
16.	Avoid foods with sugar in them.	_	_	_	_	_	_	
17.	Eat diet foods.	_	_	_	_	_	_	
18.	Feel that food controls my life.	_	_	_	_	_	_	
19.	Display self-control around food.	_	_	_	_	_	_	
20.	Feel that others pressure me to eat.	_	_	_	_	_	_	
21.	Give too much time and thought to food.	_	_	_	_	_	_	
22.	Feel uncomfortable after eating sweets.	_	_	_	_	_	_	
23.	Engage in dieting behavior.	_	_	_	_	_	_	
24.	Like my stomach to be empty.	_	_	_	_	_	_	
25.	Have the impulse to vomit after meals.	_	_	_	_	_	_	
26.	Enjoy trying new rich foods.	_	_	_	_	_	_	
							Total Score=	

1) Have you gone on eating binges where you feel that you may not be able to stop? (Eating much more than most people would eat under the same circumstances)

_ No _ Yes How many times in the last 6 months? _____

2) Have you ever made yourself sick (vomited) to control your weight or shape?

_ No _ Yes How many times in the last 6 months? _____

3) **Have you ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?**

_ No _ Yes How many times in the last 6 months? _____

4) Have you ever been treated for an eating disorder? _ No _ Yes **When?** _____

Therapist:_____ Therapist Signature:_____

Name:_____ Date:___/___/____ MR:_____

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**
☐	☐	☐	☐

Therapist:_____ Therapist Signature:_____

Name:_____ MR:_____ Date:____/____/____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
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

(For office coding: Total Score T____ = ____ + ____ + ____)

Severity Range:

___ 0-4: Minimum

___ 5-9: Mild

___ 10-14: Moderate

___ 15-21: Severe

Therapist:_____ Therapist Signature:_____

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screener/Recent – Self-Report

Name:_____ MR:_____ Date:___/___/____

	In The Past Month	
Answer Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts about killing yourself?***		
If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6		
3) ***Have you thought about how you might do this?***		
4) ***Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?***		
5) ***Have you started to work out or worked out the details of how to kill yourself?*** ***Do you intend to carry out this plan?***		
	In the Past 3 Months	
6) ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
In your entire lifetime, how many times have you done any of these things?		

Therapist Name:_____ Therapist Signature:_____

Name:_____ MR:_____ Date:___/___/_____

Alcohol Use Disorders Identification Test – AUDIT

Please select the answer that is most correct for you to each of the following questions.

1) How often do you have a drink containing alcohol? *(If you answer never, jump to questions 9&10)*

(0) Never (1) Monthly or less (2) 2-4 times a month (3) 2-3 times per week (4) 4 or more times a week

2) How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1-2 (1) 3-4 (2) 5-6 (3) 7-8 (4) 10 or more

3) How often do you have six or more drinks on one occasion?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) 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?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5) How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) 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?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7) How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8) How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9) Have you or someone else been injured as a result of your drinking?

(0) No (2) Yes, but not in the last year (3) Yes, during the last year

10) Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?

(0) No (2) Yes, but not in the last year (3) Yes, during the last year

Total Score:_____

Therapist:_____ Therapist Signature:_____

MR:_____

Patient's Name: Date:

Drug Abuse Screening Test—DAST-10

These Questions Refer to the Past 12 Months

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 unable to stop using drugs when you want to?	Yes	No
4	Have you ever 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 (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Total Score:_____

Guidelines for Interpretation of DAST-10

Interpretation (Each "Yes" response = 1)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4):363-371.
Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007;32:189-198.

Therapist:_____ Therapist Signature:_____

Name:_____ MR:_____ Date:____/____/____

Rosenberg's Self-Esteem Scale (Rosenberg, 1965)

Instructions: Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. I feel that I'm a person of worth, at least on an equal plane with others.				
2. I feel that I have a number of good qualities.				
3. All in all, I am inclined to feel that I am a failure.				
4. I am able to do things as well as most other people.				
5. I feel I do not have much to be proud of.				
6. I take a positive attitude toward myself.				
7. On the whole, I am satisfied with myself.				
8. I wish I could have more respect for myself.				
9. I certainly feel useless at times.				
10. At times I think I am no good at all.				

Total Score:_____

Scoring: To score the items, assign a value to each of the 10 items as follows:

- **For items 1, 2, 4, 6, 7:** Strongly Agree=3, Agree=2, Disagree=1, and Strongly Disagree=0.
- **For items 3, 5, 8, 9, 10** (which are reversed in valence, and noted with the asterisks** below): Strongly Agree=0, Agree=1, Disagree=2, and Strongly Disagree=3.

The scale ranges from 0-30, with 30 indicating the highest score possible. Higher scores indicate higher self-esteem. Scores below 15 indicate low self-esteem.

Therapist:_____ Therapist Signature:_____

Name:_____ MR:_____ Date:____/____/_____

Satisfaction With Life Scale (SWLS)

Instructions: Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

7 - Strongly agree

6 - Agree

5 - Slightly agree

4 - Neither agree nor disagree

3 - Slightly disagree

2 - Disagree

1 - Strongly disagree

____ In most ways my life is close to my ideal.

____ The conditions of my life are excellent.

____ I am satisfied with my life.

____ So far I have gotten the important things I want in life.

____ If I could live my life over, I would change almost nothing.

Total Score: _____

Severity Range:

31 – 35: Extremely satisfied

26 – 30: Satisfied

21 – 25: Slightly satisfied

20: Neutral

15 – 19: Slightly dissatisfied

10 – 14: Dissatisfied

5 - 9: Extremely dissatisfied

Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin as noted in the 1985 article in the *Journal of Personality Assessment.*

Therapist:_____ Therapist Signature:_____