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?** _____

EAT-26 ' David M. Garner (1982) Note: The EAT-26 has been made available with permission of the authors.

Provider: Luis Olivera-Rodriguez, MD Psychiatrist Signature: _____

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

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**
☐	☐	☐	☐

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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* ____ **=** ____ **+** ____ **+** ____ **)**

Severity Range:

__ 0-4: Minimum

__ 5-9: Mild

__ 10-14: Moderate

__ 15-21: Severe

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

CIDI Based Bipolar Disorder Screening Scale

	YES	NO
Euphoria Stem Question: 1. Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this lasting several days or longer? *If the answer is YES, skip to Criterion B screening question (3). If the answer is NO, answer the Irritability Stem Question next.*		
Irritability Stem Question: 2. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you either started arguments, shouted at people or hit people? *If the answer is YES, continue to Criterion B screening question (3). If the answer is NO, don't answer any more questions.*		
Criterion B Screening Question: 3. People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in many ways they would normally think inappropriate. Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy? *If the answer is YES, continue to answer the rest of the questions in this form. If the answer is NO, don't answer any more questions.*		
Criterion B Symptom Questions: Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?		
1. Where you so irritable that you either started arguments, shouted at people or hit people? *This first symptom question should be answered only if the euphoria stem question #1 was answered YES.*		
2. Did you become so restless or fidgety that you paced up and down or couldn't stand still?		
3. Did you do anything else that wasn't usual for you – like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?		
4. Did you try to do things that were impossible to do, like taking on large amounts of work?		
5. Did you constantly keep changing your plans or activities?		
6. Did you find it hard to keep your mind on what you were doing?		
7. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn't keep track of them?		
8. Did you sleep far less than usual and still not get tired or sleepy?		
9. Did you spend so much more money than usual that it caused you to have financial trouble?		

Total: _____

Provider: Luis Olivera-Rodriguez, MD Psychiatrist Signature:_____

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

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

Answer Questions 1 and 2 // **In the past month…**	In The Past Month: **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?		

Total: _____

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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:_____

Provider: Luis Olivera-Rodriguez, MD Psychiatrist Signature:_____

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

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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.

Name: _____ Date: __/__/____

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

Provider: Luis Olivera-Rodriguez, MD Psychiatrist 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.*

Provider: Luis Olivera-Rodriguez, MD Psychiatrist 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**.

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