Yesavage Geriatric Depression Scale (GDS-30)

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

Instructions: Answer the following questions based on how you have felt in the past two weeks.

1. Are you basically satisfied with your life?	Yes / No
2. Have you dropped many of your activities and interests?	Yes / No
3. Do you feel that your life is empty?	Yes / No
4. Do you often get bored?	Yes / No
5. Are you hopeful about the future?	Yes / No
6. Are you bothered by thoughts you can't get out of your head?	Yes / No
7. Are you in good spirits most of the time?	Yes / No
8. Are you afraid that something bad is going to happen to you?	Yes / No
9. Do you feel happy most of the time?	Yes / No
10. Do you often feel helpless?	Yes / No
11. Do you often get restless and fidgety?	Yes / No
12. Do you prefer to stay at home, rather than going out and doing new things?	Yes / No
13. Do you frequently worry about the future?	Yes / No
14. Do you feel you have more problems with memory than most?	Yes / No
15. Do you think it is wonderful to be alive now?	Yes / No
16. Do you often feel downhearted and blue?	Yes / No
17. Do you feel pretty worthless the way you are now?	Yes / No
18. Do you worry a lot about the past?	Yes / No
19. Do you find life very exciting?	Yes / No
20. Is it hard for you to get started on new projects?	Yes / No
21. Do you feel full of energy?	Yes / No
22. Do you feel that your situation is hopeless?	Yes / No
23. Do you think that most people are better off than you are?	Yes / No
24. Do you frequently get upset over little things?	Yes / No
25. Do you frequently feel like crying?	Yes / No
26. Do you have trouble concentrating?	Yes / No
27. Do you enjoy getting up in the morning?	Yes / No
28. Do you prefer to avoid social gatherings?	Yes / No
29. Is it easy for you to make decisions?	Yes / No
30. Is your mind as clear as it used to be?	Yes / No

Total:_____

Provider: Luis Olivera-Rodriguez, MD

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

Severity Range:

__ 0-4: Minimum

__ 5-9: Mild

__ 10-14: Moderate

__ 15-21: Severe

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

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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: _____

Provider: Luis Olivera-Rodriguez, MD Psychiatrist 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:_____

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: _____

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Patient Name:_____ **Date:___/___/_____**

Patient ID #_____ Caregiver Name (if applies):_____

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	**Independence** (1 Point) **NO** supervision, direction or personal assistance.	**Dependence** (0 Points) **WITH** supervision, direction, personal assistance or total care.
BATHING Points: _____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	**(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS: _____ **SCORING:** 6 = High (*patient independent*) 0 = Low (*patient very dependent*

Source:
try this: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

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

Patient Name:_____ Date:___/___/_____

Patient ID #_____ Caregiver Name (if applies):_____

LAWTON - BRODY
INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (I.A.D.L.)

Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

A. Ability to Use Telephone		**E. Laundry**	
1. Operates telephone on own initiative-looks up and dials numbers, etc.	1	1. Does personal laundry completely	1
		2. Launders small items-rinses stockings, etc.	1
2. Dials a few well-known numbers	1	3. All laundry must be done by others	0
3. Answers telephone but does not dial	1		
4. Does not use telephone at all	0		
B. Shopping		**F. Mode of Transportation**	
1. Takes care of all shopping needs independently	1	1. Travels independently on public transportation or drives own car	1
2. Shops independently for small purchases	0	2. Arranges own travel via taxi, but does not otherwise use public transportation	1
3. Needs to be accompanied on any shopping trip	0	3. Travels on public transportation when accompanied by another	1
4. Completely unable to shop	0	4. Travel limited to taxi or automobile with assistance of another	0
		5. Does not travel at all	0
C. Food Preparation		**G. Responsibility for Own Medications**	
1. Plans, prepares and serves adequate meals independently	1	1. Is responsible for taking medication in correct dosages at correct time	1
2. Prepares adequate meals if supplied with ingredients	0	2. Takes responsibility if medication is prepared in advance in separate dosage	0
3. Heats, serves and prepares meals, or prepares meals, or prepares meals but does not maintain adequate diet	0	3. Is not capable of dispensing own medication	0
4. Needs to have meals prepared and served	0		
D. Housekeeping		**H. Ability to Handle Finances**	
1. Maintains house alone or with occasional assistance (e.g. "heavy work domestic help")	1	1. Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income	1
2. Performs light daily tasks such as dish washing, bed making	1	2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness	1	3. Incapable of handling money	0
4. Needs help with all home maintenance tasks	1		
5. Does not participate in any housekeeping tasks	0		
Score		**Score**	
		Total score_____	

A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias.

Source: *try this:* Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

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**.

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