PBHCI CLINICAL REGISTRY
INSTRUCTIONS FOR USE

This registry contains seven (7) data collection forms:

1. **Patient Profile:** Completed once, at intake into PBHCI services (page 1)

2a. **Psychosocial Assessment:** One column completed at each encounter, including intake (page 2)

2b. **Psychosocial Treatment Plan**: One column completed at each encounter, including intake (page 3)

3. **Substance Use Assessment and Treatment Plan:** One column completed at each encounter, including intake (page 4)

4a. **Primary Care Assessment:** One column completed at each encounter, including intake (page 5)

4b. **Primary Care Treatment Plan:** One column completed at each encounter, including intake (page 6)

5. **Medication Reconciliation:** One column completed at each encounter, including intake (page 7)

Notes for use:

- This registry contains three types of data elements:
    1. All SAMHSA-required data elements beyond those included in NOMs/TRAC. **SAMHSA-required data elements are noted with an asterisk *.**
    2. A subset of data elements overlapping with NOMs/TRAC. These elements are included in the registry to promote assessment of patient issues with clinical implications (e.g., problems with housing) at more frequent intervals than the required bi-annual TRAC reports. These data elements are recommended but not required.
    3. Various health indicators from national standards for continuity and quality of care (e.g., HEDIS, U.S. Preventive Services Task Force). These data elements are recommended but not required.
- It is strongly recommended that you complete all registry fields in order to: (1) improve the quality of service provision, and (2) facilitate meaningful program evaluation.
- Below is a list of standardized, validated instruments that can be used to collect information for some of the SAMHSA-required (*) and recommended data elements in the PBHCI clinical registry. The list includes the LOCUS IV Recovery Environment (also recommended by SAMHSA) for the required social support data elements and the PHQ-9 for the recommended depression symptom data elements. The use of these specific instruments, although highly recommended, is not required. You may select other standardized, validated instruments that are best-suited to your specific client populations and have a high likelihood of accurately capturing changes in your clients' health status over time.

Appendix: Recommended Instruments and Scoring Instructions

1. **AUDIT:** Scores for this measure are tracked on the Substance Use Assessment and Treatment Plan form.
2. **LOCUS IV Recovery Environment Subscale**: Scores for this measure are tracked on the Psychosocial Assessment.
3. **PHQ-9:** Scores for this measure are tracked on the Psychosocial Assessment.
4. **SF-36 subscales:** Scores for this measure are tracked on the Psychosocial Assessment.

PBHCI CLINICAL REGISTRY

Integrating Behavioral and Physical Health Care
Patient Profile

MRN:	Encounter Date: mm/dd/yyyy	Location ID:
Provider Name (Last, First MI)		Provider Specialty:

A. PATIENT DEMOGRAPHICS

Patient Name (Last, First MI):

DOB: mm/dd/yyyy	Sex ☐Male ☐Female	☐Patient new to practice
Race: (check all that apply) ☐American Indian/Alaska Native ☐Asian	☐Black / African American ☐Hawaiian / Pacific Islander ☐White	☐Hispanic or Latino
County of residence:		Zip code:
Preferred language of service: ☐English ☐Spanish ☐Other		Can patient consent to own treatment? ☐No ☐Yes

Marital status:		Education (highest level):	
☐Civil union	☐Married	☐Never attended / kindergarten only	☐Grade 12 / GED
☐Cohabitating	☐Single / never married	☐Grades 1-8	☐College 1-3 yrs
☐Divorced	☐Widowed	☐Grades 9-11	☐College 4yrs or more

B. INSURANCE (Check all that apply)

☐Indian Health Service	☐Medicare (managed care)	☐None
☐Medicaid	☐Military Health Care	☐Private Health Insurance
☐Medicare (fee for service)	☐Non-US Insurance	☐State-Specific Plan (non-Medicaid)

C. PERSONAL MEDICAL HISTORY		D. FAMILY MEDICAL HISTORY	
*Cardiovascular Disease	☐Yes ☐No ☐DK	*Cardiovascular Disease	☐Yes ☐No ☐DK
*Diabetes	☐Yes ☐No ☐DK	*Diabetes	☐Yes ☐No ☐DK
*Hypertension	☐Yes ☐No ☐DK	*Hypertension	☐Yes ☐No ☐DK
Other:		Other:	
*Substance Abuse/Dependence (lifetime)	☐Yes ☐No ☐DK If yes, drug of choice? Longest clean time?	*Substance Abuse/Dependence	☐Yes ☐No ☐DK
*Tobacco (lifetime)	☐Yes ☐No ☐DK If yes, ☐Cigs ☐Smokeless Longest clean time?	*Tobacco	☐Yes ☐No ☐DK

E. MENTAL HEALTH HISTORY

Axis I (note primary):	Current GAF:
Axis II (note primary):	Highest GAF within the year:

F.*MEDICATION HISTORY

*Previous medications (list):

PBHCI CLINICAL REGISTRY			Integrating Behavioral and Physical Health Care **Psychosocial Assessment**	
	Date mm/dd/yyyy	Date mm/dd/yyyy	Date mm/dd/yyyy	Date mm/dd/yyyy
A. PSYCHOSOCIAL ISSUES				
Employ/Education problems?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Housing problems?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Legal problems?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
*Social support (LOCUS IV Recov[a])	☐No ☐Yes Score:	☐No ☐Yes Score:	☐No ☐Yes Score:	☐No ☐Yes Score:
B. MENTAL HEALTH SYMPTOMS				
Depression (e.g. PHQ-9 score)				
Other:				
Other:				
C. GENERAL HEALTH / WELL-BEING (e.g.,SF-36 and subscales[a])				
General mental health				
Bodily pain				
General health perc.				
Physical functioning				
Role limitations, MH				
Role limitations, PH				
Social functioning				
Vitality				
D. SUICIDE				
Feel suicidal?	☐No ☐Yes Contract for safety:	☐No ☐Yes Contract for safety:	☐No ☐Yes Contract for safety:	☐No ☐Yes Contract for safety:
Suicide attempts in last 30 days?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
E. HOSPITAL USE				
Psych inpatient in last 30 days?	☐No ☐Yes Total days:	☐No ☐Yes Total days:	☐No ☐Yes Total days:	☐No ☐Yes Total days:
ER visits in last 30 days?	☐No ☐Yes Total visits:	☐No ☐Yes Total visits:	☐No ☐Yes Total visits:	☐No ☐Yes Total visits:

[a] Scoring instructions in Appendix

PBHCI CLINICAL REGISTRY

Integrating Behavioral and Physical Health Care
Psychosocial Treatment Plan

	Date mm/dd/yyyy Clinician		Date mm/dd/yyyy Clinician		Date mm/dd/yyyy Clinician		Date mm/dd/yyyy Clinician	
Problem Type (Check all that apply)	Tx Goals (List all)	Actions (Check all that apply)	Goal Status	Actions (Check all that apply)	Goal Status	Actions (Check all that apply)	Goal Status	Actions (Check all that apply)
A. PSYCHOSOCIAL								
☐Employment/ Education		☐ Consult with CM ☐ Referral ☐ Other:	Met: Not:	☐ Consult with CM ☐ Referral ☐ Other:	Met: Not:	☐ Consult w CM ☐ Referral: ☐ Other:	Met: Not:	☐ Consult w CM ☐ Referral: ☐ Other:
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
☐Housing		☐ Consult with CM ☐ Referral ☐ Other:		☐ Consult with CM ☐ Referral ☐ Other:		☐ Consult with CM ☐ Referral ☐ Other:		☐ Consult with CM ☐ Referral ☐ Other:
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
☐Legal		☐ Consult with CM ☐ Referral ☐ Other:		☐ Consult with CM ☐ Referral ☐ Other:		☐ Consult with CM ☐ Referral ☐ Other:		☐ Consult with CM ☐ Referral ☐ Other:
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
☐Social Support		☐ Consult with CM ☐ Referral ☐ Other:		☐ Consult with CM ☐ Referral ☐ Other:		☐ Consult with CM ☐ Referral ☐ Other:		☐ Consult with CM ☐ Referral ☐ Other:
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
B. MENTAL HEALTH								
☐Diagnosis/ Symptom:		☐ Psychotherapy type: _____ ☐ Start/Stop date:_____ ☐ Med add/dc/chng ☐ Referral: ☐ Other:	Met: Not:	☐ Psychotherapy type: _____ ☐ Start/Stop date:_____ ☐ Med add/dc/chng ☐ Referral: ☐ Other:	Met: Not:	☐ Psychotherapy type: _____ ☐ Start/Stop date:_____ ☐ Med add/dc/chng ☐ Referral: ☐ Other:	Met: Not:	☐ Psychotherapy type: _____ ☐ Start/Stop date:_____ ☐ Med add/dc/chng ☐ Referral: ☐ Other:
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
☐ Diagnosis/ Symptom:		☐ Psychotherapy type: _____ ☐ Start/Stop date:_____ ☐ Med add/dc/chng ☐ Referral: ☐ Other:	Met: Not:	☐ Psychotherapy type: _____ ☐ Start/Stop date:_____ ☐ Med add/dc/chng ☐ Referral: ☐ Other:	Met: Not:	☐ Psychotherapy type: _____ ☐ Start/Stop date:_____ ☐ Med add/dc/chng ☐ Referral: ☐ Other:	Met: Not:	☐ Psychotherapy type: _____ ☐ Start/Stop date:_____ ☐ Med add/dc/chng ☐ Referral: ☐ Other:
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:

PBHCI CLINICAL REGISTRY			Integrating Behavioral and Physical Health Care **Substance Use Assessment and Treatment Plan**	
	Date : mm/dd/yyyy	Date: mm/dd/yyyy	Date: mm/dd/yyyy	Date: mm/dd/yyyy
A. ALCOHOL				
***A**sk: Risky drinking[a] in last 30 days?	☐No ☐Yes Describe:	☐No ☐Yes Describe:	☐No ☐Yes Describe:	☐No ☐Yes Describe:
AUDIT[a] score				
Advise to reduce to moderate levels?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Assess patient's goals	☐No ☐Yes Describe:	☐No ☐Yes Describe:	☐No ☐Yes Describe:	☐No ☐Yes Describe:
Assist with treatment Check all that apply	☐Behavioral Intervention ☐Medication - add/dc/chng ☐Referral to: ☐Other:	☐Behavioral Intervention ☐Medication - add/dc/chng ☐Referral to: ☐Other:	☐Behavioral Intervention ☐Medication - add/dc/chng ☐Referral to: ☐Other:	☐Behavioral Intervention ☐Medication - add/dc/chng ☐Referral to: ☐Other:
Arrange follow-up	Who: When:	Who: When:	Who: When:	Who: When:
B. ILLICIT DRUGS				
***A**sk: Illicit drug use in last 30 days?	☐No ☐Yes Describe:	☐No ☐Yes Describe:	☐No ☐Yes Describe:	☐No ☐Yes Describe:
Advise to quit?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Assess: Willing to quit?	☐No ☐Yes When:	☐No ☐Yes When:	☐No ☐Yes When:	☐No ☐Yes When:
Assist with treatment Check all that apply	☐Behavioral Intervention ☐Medication - add/dc/chng ☐Referral to: ☐Other:	☐Behavioral Intervention ☐Medication - add/dc/chng ☐Referral to: ☐Other:	☐Behavioral Intervention ☐Medication - add/dc/chng ☐Referral to: ☐Other:	☐Behavioral Intervention ☐Medication - add/dc/chng ☐Referral to: ☐Other:
Arrange follow-up	Who: When:	Who: When:	Who: When:	Who: When:
C. TOBACCO				
***A**sk: Use in last 30 days?	☐No ☐Yes Describe:	☐No ☐Yes Describe:	☐No ☐Yes Describe:	☐No ☐Yes Describe:
Advise to quit?	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
Assess: Willing to quit?	☐No ☐Yes When:	☐No ☐Yes When:	☐No ☐Yes When:	☐No ☐Yes When:
Assist to quit: Check all that apply	☐Behavioral Intervention ☐Med/NRT - add/dc/chng ☐Referral to: ☐Other:	☐Behavioral Intervention ☐Med/NRT - add/dc/chng ☐Referral to: ☐Other:	☐Behavioral Intervention ☐Med/NRT - add/dc/chng ☐Referral to: ☐Other:	☐Behavioral Intervention ☐Med/NRT - add/dc/chng ☐Referral to: ☐Other:
Arrange follow-up	Who: When:	Who: When:	Who: When:	Who: When:

[a] Scoring instructions in Appendix

PBHCI CLINICAL REGISTRY

Integrating Behavioral and Physical Health Care
Primary Care Assessment

	Date mm/dd/yyyy		Date mm/dd/yyyy		Date mm/dd/yyyy		Date mm/dd/yyyy	
A. PHYSICAL EXAM	Value	Flag	Value	Flag	Value	Flag	Value	Flag
*Height (inches) [1]		☐		☐		☐		☐
*Weight (lbs) [1]		☐		☐		☐		☐
*BMI (lbs) [1]		☐		☐		☐		☐
Waist circ. (inches)		☐		☐		☐		☐
*BP (mmHg) [1]		☐		☐		☐		☐
Pulse (bpm)		☐		☐		☐		☐
Respiration/min		☐		☐		☐		☐
Eye		☐		☐		☐		☐
Foot		☐		☐		☐		☐
Skin		☐		☐		☐		☐
Thyroid		☐		☐		☐		☐
Other (specify)		☐		☐		☐		☐
		☐		☐		☐		☐
		☐		☐		☐		☐
B. LABS								
*LDL Cholesterol [2]		☐		☐		☐		☐
*HDL Cholesterol [2]		☐		☐		☐		☐
*Total Cholesterol [2]		☐		☐		☐		☐
*Triglycerides [2]		☐		☐		☐		☐
*Glucose / HbA1C [2]		☐		☐		☐		☐
LFT		☐		☐		☐		☐
Albumin		☐		☐		☐		☐
Urine Creatinine		☐		☐		☐		☐
GFR		☐		☐		☐		☐
TSH		☐		☐		☐		☐
Urine drug screen (specify)		☐		☐		☐		☐
Other (specify)		☐		☐		☐		☐
		☐		☐		☐		☐
		☐		☐		☐		☐

[1] At least quarterly [2] At least annually

PBHCI CLINICAL REGISTRY

Integrating Behavioral and Physical Health Care
Primary Care Treatment Plan

	Date mm/dd/yyyy Clinician		Date mm/dd/yyyy Clinician		Date mm/dd/yyyy Clinician		Date mm/dd/yyyy Clinician	
Problem Type (Check all that apply)	Tx Goals (List all)	Actions (Check all that apply)	Goal Status	Actions (Check all that apply)	Goal Status	Actions (Check all that apply)	Goal Status	Actions (Check all that apply)
☐*Diabetes Specific dx: (list all)		☐ Diabetes Educat. ☐ Diet ☐ Phys Activity ☐ Med add/dc/chng ☐ Referral: Other:	Met: Not:	☐ Diabetes Educat. ☐ Diet ☐ Phys Activity ☐ Med add/dc/chng ☐ Referral: Other:	Met: Not:	☐ Diabetes Educat. ☐ Diet ☐ Phys Activity ☐ Med add/dc/chng ☐ Referral: Other:	Met: Not:	☐ Diabetes Educat. ☐ Diet ☐ Phys Activity ☐ Med add/dc/chng ☐ Referral: Other:
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
☐*Hypertension Specific dx: (list all)		☐ HTN Educat. ☐ Diet ☐ Phys Activity ☐ Med add/dc/chng ☐ Referral: Other:	Met: Not:	☐ HTN Educat. ☐ Diet ☐ Phys Activity ☐ Med add/dc/chng ☐ Referral: Other:	Met: Not:	☐ HTN Educat. ☐ Diet ☐ Phys Activity ☐ Med add/dc/chng ☐ Referral: Other:	Met: Not:	☐ HTN Educat. ☐ Diet ☐ Phys Activity ☐ Med add/dc/chng ☐ Referral: Other:
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
☐*Obesity Specific dx: (list all)		☐ Obesity Educat. ☐ Diet ☐ Phys Activity ☐ Behavioral Interv. ☐ Med add/dc/chng ☐ Referral: Other:	Met: Not:	☐ Obesity Educat. ☐ Diet ☐ Phys Activity ☐ Behavioral Interv. ☐ Med add/dc/chng ☐ Referral: Other:	Met: Not:	☐ Obesity Educat. ☐ Diet ☐ Phys Activity ☐ Behavioral Interv. ☐ Med add/dc/chng ☐ Referral: Other:	Met: Not:	☐ Obesity Educat. ☐ Diet ☐ Phys Activity ☐ Behavioral Interv. ☐ Med add/dc/chng ☐ Referral: Other:
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
☐Other Specific dx: (list all)			Met: Not:		Met: Not:		Met: Not:	
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
☐Other Specific dx: (list all)			Met: Not:		Met: Not:		Met: Not:	
Follow-up		Who: When:		Who: When:		Who: When:		Who: When:
☐Other Specific dx: (list all)			Met: Not:		Met: Not:		Met: Not:	
Follow-up		Who: When		Who: When:		Who: When:		Who: When:

PBHCI CLINICAL REGISTRY			Integrating Behavioral and Physical Health Care **Medication Reconciliation**	
	Date mm/dd/yyyy	Date mm/dd/yyyy	Date mm/dd/yyyy	Date mm/dd/yyyy
A. *PSYCH MEDS (list all)	*Current Dose or D/C	*Current Dose or D/C	*Current Dose or D/C	*Current Dose or D/C
B. *OTHER MEDS (list all)	*Current Dose or D/C	*Current Dose or D/C	*Current Dose or D/C	*Current Dose or D/C

APPENDIX

Alcohol Use Disorders Identification Test (AUDIT)

Circle one answer for each question. Keep track of your total points.

1. How often do you have a drink containing alcohol? **(0) Never = Skip to questions 9-10** (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	6. 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
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more	7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
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	8. 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
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	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
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	10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year

Scoring: Sum total points. A score of 8 or higher indicates a drinking problem; **Reference:** Saunders, J.B. et al (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with harmful Alcohol Consumption-II. *Addiction, 88*, 791-804.

Risky Drinking: Women: More than 7 drinks per week OR more than 3 drinks per occasion. Men: More than 14 drinks per week or more than 4 drinks per occasion. **Reference:** U.S. Preventive Services Task Force, Recommendations for Alcohol Screening, Adults

LOCUS IV/ RECOVERY ENVIRONMENT SCORE

Scoring Instructions: Each evaluation parameter is defined along a scale of one to five. Each score in the scale is defined by one or more criteria, which are designated by separate letters. Only one of these criteria need be met for a score to be assigned to the subject. The evaluator should select the highest score or rating in which at least one of the criteria is met. There will, on occasion, be instances where there will be some ambiguity about whether a subject has met criteria for a score on the scale within one of the parameters. This may be due to inadequate information, conflicting information, or simply to difficulty in making a judgment about whether the available information is consistent with any of the criteria for that score. Clinical experience must be applied judiciously in making determinations in this regard, and the rating or criterion that provides the closest approximation to the actual circumstance should be selected. However, there will be instances when it will remain difficult to make this determination. In these cases the highest score in which it is more likely than not that least one criterion has been met should generally be assigned. The result will be that any errors will be made on the side of caution

1 - Highly Supportive Environment

☐ a- Abundant sources of support with ample time and interest to provide for both material and emotional needs in all circumstances.
☐ b- Effective involvement of Assertive Community Treatment Team (ACT) or other similarly highly supportive resources.
(Selection of this criterion pre-empts higher ratings)

2 - Supportive Environment

☐ a- Supportive resources are not abundant, but are capable of and willing to provide significant aid in times of need.
☐ b- Some elements of the support system are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.
☐ c- Professional supports are available and effectively engaged (i.e. ICM).
(Selection of this criterion pre-empts higher ratings)

3 - Limited Support in Environment

☐ a- A few supportive resources exist in current environment and may be capable of providing some help if needed.
☐ b- Usual sources of support may be somewhat ambivalent, alienated, difficult to access, or have a limited amount of resources they are willing or able to offer when needed.
☐ c- Persons who have potential to provide support have incomplete ability to participate in treatment and make necessary changes.
☐ d- Resources may be only partially utilized even when available.
☐ e- Limited constructive engagement with any professional sources of support which are available.

4 - Minimal Support in Environment

☐ a- Very few actual or potential sources of support are available.
☐ b- Usual supportive resources display little motivation or willingness to offer assistance or they are dysfunctional or hostile toward client.
☐ c- Existing supports are unable to provide sufficient resources to meet material or emotional needs.
☐ d- Client may be alienated and unwilling to use supports available in a constructive manner.

5 - No Support in Environment

☐ a- No sources for assistance are available in environment either emotionally or materially.

Reference: LOCUS: LEVEL OF CARE UTILIZATION SYSTEM FOR PSYCHIATRIC AND ADDICTION SERVICES. Adult Version 2010, AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS. March 20, 2009 © 1996-2009 American Association of Community Psychiatrists

The Patient Health Questionnaire: PHQ-9 — Nine Symptom Checklist

Scoring for diagnosis:
-5 or more are circled as at least “more than half the days”
-Either item 1a or 1b is at least “more than half the days”
Scoring for planning and monitoring treatment:
-To score the first question, tally each response by the number value of each response.
-Add the numbers together to total the score.
-Interpret the score by using the guide below:

Score	Action
≤4	Treatment for depression may not be needed
> 5-14	Physician uses clinical judgment about treatment, based on patient’s duration of symptoms and functional impairment
≥15	Warrants treatment for depression, using antidepressant, psychotherapy, or combination of treatment.

-For question 2, if the patient responds “very difficult” or “extremely difficult”, functionality is impaired. After treatment begins, the functional status is measured again to see if the patient is improving.

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

	Not at all	Several Days	More than half the days	Nearly every day
1a. Little interest or pleasure in doing things	0	1	2	3
1b. Feeling down, depressed, or hopeless	0	1	2	3
1c. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
1d. Feeling tired or having little energy	0	1	2	3
1e. Poor appetite or overeating	0	1	2	3
1f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down.	0	1	2	3
1g. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
1h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
1i. Thinking that you would be better off dead or that you want to hurt yourself in some way.	0	1	2	3
2. If you checked off any problem on this questionnaire so far, 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 at all difficult	Somewhat difficult	Very difficult	Extremely difficult

Reference: Kroenke, K., Spitzer, R.L., & Williams, J.B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*, 606-13.

SHORT-FORM 36 (SF-36)

1. In general, would you say your health is: Excellent = 1, Very Good = 2, Good = 3, Fair = 4, Poor = 5

2. Compared to one year ago, how would you rate your health in general now? Much better than one year ago = 1, Somewhat better now than one year ago = 2, About the same = 3, Somewhat worse now than one year ago = 4, Much worse now than one year ago = 5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at All
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
5. Lifting or carrying groceries	1	2	3
6. Climbing several flights of stairs	1	2	3
7. Climbing one flights of stairs	1	2	3
8. Bending, kneeling, or stooping	1	2	3
9. Walking more than a mile	1	2	3
10. Walking several blocks	1	2	3
11. Walking one block	1	2	3
12. Bathing or dressing yourself	1	2	3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (Circle one number on each line)

	Yes	No
13. Cut down the amount of time you spent on work or other activities	1	2
14. Accomplished less than you would like	1	2
15. Were limited in the kind of work of other activities	1	2
16. Had difficulty performing the work or other activities (for example, it took extra effort)	1	2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? (Circle one number on each line)

	Yes	No
17. Cut down the amount of time you spent on work or other activities	1	2
18. Accomplished less than you would like	1	2
19. Didn't do work other activities as carefully as usual	1	2

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (Circle one number)
Not at all = 1, Slightly = 2, Moderately = 3, Quite a bit = 4, Extremely = 5

21. How much bodily pain have you had during the past 4 weeks? (Circle one number)

None = 1, Very mild = 2, Mild = 3, Moderate = 4, Severe = 5, Very severe = 6

22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework?) (Circle one number)
Not at all = 1, A little bit = 2, Moderately = 3, Quite a bit = 4, Extremely = 5

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks… (Circle one number on each line)

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt do down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? (Circle one number)
All of the time = 1, Most of the time = 2, Some of the time = 3, A little of the time = 4, None of the time = 5

How true or false is each of the following statement for you.
(Circle one number on each line)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

Scoring: Subscales scores are a summation of each subset of items. General mental health=items 24-26, 28, 30, Bodily pain=items 21-22, General health perc.=items 1, 33-36, Physical functioning=items 3-12, Role limitations, MH=items 17-19, Role limitations, PH=items 13-16, Social functioning=items 20, 32, Vitality=items 23, 27, 29, 31

Reference: Ware, J.E., & Sherbourne, C.D. (1992). The MOS 36-Item Short Form Health Survey (SF-36): Conceptual framework and item selection. *Medical Care, 30*, 473-481.