Riverside MEDICAL GROUP ADULT MEDICINE

Hackensack University Medical Group

DEPRESSION & ALCOHOL

Patient Name: ________________________ **Date of Birth:** ____________________ **Date:** ____________________

How often during the **past 2 weeks** were you bothered by …	**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 your 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 TV	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

Total Score: ________________

CAGE-AID Questionnaire

1.	Have you ever felt that you ought to cut down on your drinking or drug use?	Yes	No
2.	Have people annoyed you by criticizing your drinking or drug use?	Yes	No
3.	Have you ever felt bad or guilty about your drinking or drug use?	Yes	No
4.	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	Yes	No

Screening is: Positive / Negative