Today's date…….. **NEW PATIENT QUESTIONNAIRE (age 16y and over) – DARWEN HEALTHCARE**

Full name		**Title**	
Mobile telephone number		**Date of Birth**	
E-mail address		**Occupation**	
Ethnic group		**Height**	
Language spoken		**Weight**	
Allergies/Intolerances		**Sex**	**male/female**
Women only: date of last cervical smear and result			

SMOKING	**Please tick**			
Never smoked				
Smoker		**Amount smoked**	**Age started Smoking**	**Are you interested in stopping smoking: yes/no** ***Please ask at reception for details of NHS stop smoking service****
Ex-smoker		**Amount smoked**	**Date stopped smoking**	

ALCOHOL INTAKE	**Please tick the boxes that apply to you and add up the points to find your total**				
	Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
MEN: How often do you have EIGHT or more drinks on one occasion?	□ **0 points**	□ **1 point**	□ **2 points**	□ **3 points**	□ **4 points**
WOMEN: How often do you have SIX or more drinks on one occasion?	□ **0 points**	□ **1 point**	□ **2 points**	□ **3 points**	□ **4 points**
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	**Never** □ **0 points**	**Less than monthly** □ **1 point**	**Monthly** □ **2 points**	**Weekly** □ **3 points**	**Daily or almost daily** □ **4 points**
How often during the last year have you failed to do what was normally expected of you because of drinking?	**Never** □ **0 points**	**Less than monthly** □ **1 point**	**Monthly** □ **2 points**	**Weekly** □ **3 points**	**Daily or almost daily** □ **4 points**
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	**No** □ **0 points**		**Yes, on one occasion** □ **2 points**		**Yes, on more than one occasion** □ **4 points**
Total for each column:					
Add the columns together for the total score	*				

***If you have scored 3 or more please complete the next 3 questionnaires in addition – thank you.**

Please list any medication you are currently taking

AUDIT C ALCOHOL QUESTIONNAIRE

	Scoring System					
QUESTIONS	**0**	**1**	**2**	**3**	**4**	**YOUR SCORE**
How often do you have a drink containing alcohol?	**Never**	**Monthly or less**	**2-4 times per month**	**2-3 times per week**	**4+ times per week**	
How many units of alcohol do you drink on a typical day when you are drinking?	**1-2**	**3-4**	**5-6**	**7-9**	**10+**	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
How often during the last year have you found that you were not able to stop drinking once you had started?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
How often during the last year have you had a feeling of guilt or remorse after drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
Have you or somebody else been injured as a result of your drinking?	**No**		**Yes, but not in the last year**		**Yes, during the last year**	

SCORING: 0-7 Lower risk, 8-15 Increasing risk, 16-19 Higher risk, 20+ Possible dependence

TOTAL SCORE

If your score is 8 – 19: Advice regarding your alcohol intake can be found on the 'Change for Life' website http://www.nhs.uk/change4life/Pages/change-for-life.aspx, or alternatively, make an appointment with one of our healthcare assistants for a well person check.
If your score is 20+: Please make a routine appointment with your GP.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems? *(Please circle to indicate you answer*	Not at all sure	Several days	Over 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's 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	0 +	+	+	
		= Total Score:		

If you checked off any problems, how difficult have these 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 _____

Patient Health Questionnaire -9 (PHQ9)

Over the last 2 weeks, how often have you been bothered by the following problems? *(Please circle to indicate you answer)*	**Not at all**	**Several days**	**Over 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 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 away	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 _____