Patient Screening Form

Name:_____**DOB:**_____**Today's Date:**_____

Once a year, all our patients are asked to complete this form because these factors can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

If you think back over the last month, how would you rate your overall wellbeing? *Consider things such as physical and mental health, social support/relationships, both successes and challenges.*				
Very difficult	Generally difficult	Neither good nor bad	Generally good	Very good

One Key Question®

Would you like to become pregnant in the next year?	Yes	I'm okay either way	No	I don't know

Mood and Emotional Health

Over the past two (2) weeks, how often have you been bothered by any of the following problems?				
Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed or hopeless	Not at all	Several days	More than half the days	Nearly every day
Feeling bad about yourself- or that you are a failure or have let yourself or your family down?	Not at all	Several days	More than half the days	Nearly every day
Trouble concentrating on things, such as reading the newspaper or watching television?	Not at all	Several days	More than half the days	Nearly every day
Moving or speaking so slowly that other people could have noticed. Or the opposite- being so figety or restless that you have been moving around a lot more than usual?	Not at all	Several days	More than half the days	Nearly every day
Thoughts that you would be better off dead, or of hurting yourself?	Not at all	Several days	More than half the days	Nearly every day

Interpersonal Relationships

In the past year, how often does anyone, including your family…					
physically hurt you? (hit slapped, kicked, choked or otherwise)	Never	Rarely	Sometimes	Fairly often	Frequently
insult or talk down to you?	Never	Rarely	Sometimes	Fairly often	Frequently
threaten you with harm?	Never	Rarely	Sometimes	Fairly often	Frequently
scream or curse at you?	Never	Rarely	Sometimes	Fairly often	Frequently

Does your partner control where you go or make you feel afraid?	Never	Rarely	Sometimes	Fairly often	Frequently
Does your partner interfere with your birth control or pressure you to get pregnant when you don't want to?	Never	Rarely	Sometimes	Fairly often	Frequently
Has anyone forced you to perform sexual activities that made you feel uncomfortable?	Never	Rarely	Sometimes	Fairly often	Frequently

Housing

What is your housing situation today?
☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park).
☐ I have housing today, but I am worried about losing housing in the future.
☐ I have housing.

Food Insecurity

Within the past 12 months, you worried that your food would run out before you got money to buy more…				
Never	Rarely	Sometimes	Fairly often	Frequently
Within the past 12 months, the food you bought just didn't last any you didn't have the money to get more…				
Never	Rarely	Sometimes	Fairly often	Frequently

Tobacco Use

Do you use tobacco products (cigarettes, chewing tobacco, vaping)?	
Yes	No

If yes, what type of tobacco product? _____

If you smoke, how many cigarettes per day?			
Less than 5	5-10	10-20	Greater than 20

If you use tobacco products, would you like help quitting?	
Yes	No

Substance Use

Have you used marijuana/ cannabis in the last year?						
Never	Monthly or less	Several days per month	Weekly	2-3 times a week	4-6 times a week	daily
How often have you used prescription medications that were not prescribed to you?						
		No/never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How often have you taken your own prescription medication more than the way it was prescribed or for different reasons than its intended purpose?						
		No/never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
Have you used other drugs in the past year (for example opiates, amphetamines, ecstasy, heroin, cocaine, LSD, mushrooms.)?						
		No/never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week

1 standard drink* is equivalent to:

1 bottle of beer | 1 shot of spirits | 1 glass of wine | 1 glass of liqueur

In the last year, how often do you have a drink containing alcohol?						
Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily
In the last year, when you drink alcohol, how many drinks do you typically have on any given day?						
1 drink	2 drinks	3 drinks	4 drinks	5 – 6 drinks	7 – 8 drinks	10 or more
In the last year, how often have you had 4 or more drinks on one occasion?						
Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily
How often during the past 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 failed to do what was expected of you because of drinking?						
Never	Less than monthly	Monthly	Weekly	Daily or almost daily		
Has a relative, friend, doctor, or other health care provider been concerned about your drinking and suggested you cut down?						
No	Yes, but not in the past year	Yes, during the past year				

Dental Needs

When was your last routine dental cleaning? _____

Do you have an established dentist? _____