Patient Stress Questionnaire*

Name: ___________________________ Date of Birth: ___________ Date of visit: ___________

Over the last two weeks, how often have you been bothered by any of the following problems? (please circle your answer & check the boxes that apply to you)  

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. ☐ Trouble falling or staying asleep, or ☐ sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. ☐ Poor appetite or ☐ overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. ☐ Moving or speaking so slowly that other people could have noticed, or ☐ the opposite - being so fidgety or restless that you've been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. ☐ Thoughts that you would be better off dead, or ☐ hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Total

(10) add columns:

<table>
<thead>
<tr>
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<th>Several days</th>
<th>More than half the days</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Total

*adapted from PHQ 9, GAD7, PC-PTSD and AUDIT 1/24/11

Practitioner's Initials: ______________________

Please also complete back side
In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?  
   - No  
   - Yes

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?  
   - No  
   - Yes

3. Were constantly on guard, watchful, or easily startled?  
   - No  
   - Yes

4. Felt numb or detached from others, activities, or your surroundings?  
   - No  
   - Yes

Alcohol and drugs can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking or drug. Please answer below:

**Drugs:** Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?

<table>
<thead>
<tr>
<th>None</th>
<th>1 or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Alcohol:** Please circle your answer

<table>
<thead>
<tr>
<th>How often do you have one drink containing alcohol?</th>
<th>Never</th>
<th>Monthly or less</th>
<th>2-4 times a month</th>
<th>2-3 times a week</th>
<th>4+ times per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>1 or 2</td>
<td>3 or 4</td>
<td>5 or 6</td>
<td>7 to 9</td>
<td>10 or more</td>
</tr>
<tr>
<td>How often do you have four or more drinks on one occasion?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
</tbody>
</table>

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 |
| …failed to do what was normally expected from you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| …needed a first drink in the morning to get yourself going after heavy drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| …had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| …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 someone else been injured as a result of your drinking?  
- No  
- Yes, but not in the last year  
- Yes, during the last year

Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?  
- No  
- Yes, but not in the last year  
- Yes, during the last year

Total:
Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often…
   - Swear at you, insult you, put you down, or humiliate you?
     - Yes  No  If yes enter 1  
   - Act in a way that made you afraid that you might be physically hurt?
     - Yes  No  If yes enter 1  

2. Did a parent or other adult in the household often or very often…
   - Push, grab, slap, or throw something at you?
     - Yes  No  If yes enter 1  
   - Ever hit you so hard that you had marks or were injured?
     - Yes  No  If yes enter 1  

3. Did an adult or person at least 5 years older than you ever…
   - Touch or fondle you or have you touch their body in a sexual way?
     - Yes  No  If yes enter 1  
   - Attempt or actually have oral, anal, or vaginal intercourse with you?
     - Yes  No  If yes enter 1  

4. Did you often or very often feel that …
   - No one in your family loved you or thought you were important or special?
     - Yes  No  If yes enter 1  
   - Your family didn’t look out for each other, feel close to each other, or support each other?
     - Yes  No  If yes enter 1  

5. Did you often or very often feel that …
   - You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?
     - Yes  No  If yes enter 1  
   - Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
     - Yes  No  If yes enter 1  

6. Were your parents ever separated or divorced?
   - Yes  No  If yes enter 1  

7. Was your mother or stepmother:
   - Often or very often pushed, grabbed, slapped, or had something thrown at her?
     - Yes  No  If yes enter 1  
   - Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
     - Yes  No  If yes enter 1  
   - Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
     - Yes  No  If yes enter 1  

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   - Yes  No  If yes enter 1  

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   - Yes  No  If yes enter 1  

10. Did a household member go to prison?
    - Yes  No  If yes enter 1  

Now add up your “Yes” answers:_______This is your ACE Score.