CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
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?	☐	☐

Permission for use granted by Richard Brown, MD.

CAGE-AID - Overview

The CAGE-AID is a conjoint questionnaire where the focus of each item of the CAGE questionnaire was expanded from alcohol alone to include alcohol and other drugs.

Clinical Utility

Potential advantage is to screen for alcohol and drug problems conjointly rather than separately.

Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited[1]:	**Sensitivity**	**Specificity**
One or more **Yes** responses	0.79	0.77
Two or more **Yes** responses	0.70	0.85

1. *Brown RL, Rounds, LA. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. Wisconsin Medical Journal. 1995:94(3) 135-140.*

Opioid Risk Tool

Introduction

The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

PHQ-9 for ADULTS
Patient Health Questionnaire

Name: _____ Date: _____

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? (Please **CIRCLE** to indicate your answer)	**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 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 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

Note: Clinic Staff - Please file electronically in the EpicCare PHQ9 Document Flow sheet.

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc.

GroupHealth.

Additional Depression Questions for Adults

Name: _____ Date: _____

Instructions: This questionnaire will help us understand how you have been feeling. The results will help you and your doctor follow your progress.

Patient Questionnaire (Please **CIRCLE** to indicate your answer.)	Y, N or N/A		
1. Have your symptoms of depression lasted longer than two years?	Y	N	N/A
2. Have you had similar symptoms lasting at least two weeks in the past? If yes, how many times?	Y	N	N/A
3. Have you had counseling in the past for depression?	Y	N	N/A
4. If you have taken medications for depression in the past, did they help?	Y	N	N/A
5. If you have taken medications for depression in the past, did you have a problem with any medication?	Y	N	N/A
6. Have you ever made plans to harm or kill yourself?	Y	N	N/A
7. Has any family member attempted or committed suicide?	Y	N	N/A
8. At any point in your life, have you gone through periods when you felt the opposite of being depressed—very "high" or "speeded up," with lots of energy? Didn't need sleep? Felt you could do anything? Circle "yes" if you had these symptoms and they lasted at least a few days and caused trouble for you in your life.	Y	N	N/A
9. In the past two weeks, have you heard or seen things that other people couldn't see or hear that might really not be there?	Y	N	N/A
10. Have you recently been the victim of threats, physical hurting, or forced sexual contact?	Y	N	N/A
11. Have you recently experienced the death of a close friend or family member?	Y	N	N/A
12. Have you recently experienced some stressful event or life change?	Y	N	N/A
13. In your life have you ever had any experience that was so frightening, horrible, or upsetting that in the past month you: • Have had nightmares about it or thought about it when you did not want to? • Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? • Were constantly on guard from others, activities, or your surroundings?	Y	N	N/A
14. In the past 12 months, have you used drugs other than those required for medical reasons?	Y	N	N/A
15. How often did you have 1 drink containing alcohol in the last year? ☐ Never [0] ☐ Monthly or less [1] ☐ 2 to 4 times per month [2] ☐ 2 to 3 times per week [3] ☐ 4 or more times per week [4]			
16. How many drinks containing alcohol did you have on a typical day when you were drinking in the last year? ☐ I don't drink alcohol [0] ☐ 1 to 2 [0] ☐ 3 to 4 [1] ☐ 5 to 6 [2] ☐ 7 to 9 [3] ☐ 10 or more [4]			
17. How often did you have 6 or more drinks on one occasion in the last year? ☐ Never [0] ☐ Less than monthly [1] ☐ Monthly [2] ☐ Weekly [3] ☐ Daily or almost daily [4]			

18. Over the last two weeks, how often have you been bothered by the following problems:	Not at all [0]	Several days [1]	Over half the days [2]	Nearly every day [3]
• Feeling nervous, anxious, or on edge?	Not at all [0]	Several days [1]	Over half the days [2]	Nearly every day [3]
• Not being able to stop or control worrying?				

Clinic Staff - Please file electronically in the EpicCare PHQ9 Document Flow sheet.

PHQ-9 for ADOLESCENTS
Modified Patient Health Questionnaire

Name: _____ Date: _____

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? (Please **CIRCLE** to indicate your answer)	**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, irritable, 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, weight loss, 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 school work, reading 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 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

Note: Clinic Staff - Please file electronically in the EpicCare PHQ9A Document Flow sheet.

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc.

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GroupHealth.

Additional Depression Questions for Adolescents

Name: _____ Date: _____

Instructions: This questionnaire will help us understand how you have been feeling. The results will help you and your doctor follow your progress.

Patient Questionnaire	(Please **CIRCLE** to indicate your answer.)		Y, N or N/A
1. Have your symptoms of depression lasted longer than two years?	Y	N	N/A
2. Have you had similar symptoms lasting at least two weeks in the past? If yes, how many times?	Y	N	N/A
3. Have you had counseling in the past for depression?	Y	N	N/A
4. If you have you taken medications for depression in the past, did they help?	Y	N	N/A
5. If you have taken medications for depression in the past, did you have a problem with any medication?	Y	N	N/A
6. Have you ever made plans to harm or kill yourself?	Y	N	N/A
7. Has any family member attempted or committed suicide?	Y	N	N/A
8. At any point in your life, have you gone through periods when you felt the opposite of being depressed—very "high" or "speeded up," with lots of energy? Didn't need sleep? Felt you could do anything? Circle "yes" if you had these symptoms and they lasted at least a few days and caused trouble for you in your life.	Y	N	N/A
9. In the past two weeks, have you heard or seen things that other people couldn't see or hear that might really not be there?	Y	N	N/A
10. Has anyone ever hit you or touched you in a way that made you uncomfortable or afraid?	Y	N	N/A
11. Have you recently experienced the death of a close friend or family member?	Y	N	N/A
12. Are you having difficulty with school work?	Y	N	N/A
13. Are you having trouble with fighting or any kind of bullying?	Y	N	N/A
14. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	Y	N	N/A
15. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	Y	N	N/A
16. Do you ever use alcohol or drugs while you are by yourself, alone?	Y	N	N/A
17. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	Y	N	N/A
18. Do you ever forget things you did while using alcohol or drugs?	Y	N	N/A
19. Have you gotten into trouble while you were using alcohol or drugs?	Y	N	N/A

20. Over the last two weeks, how often have you been bothered by the following problems:	Not at all [0]	Several days [1]	Over half the days [2]	Nearly every day [3]
• Feeling nervous, anxious, or on edge?	Not at all [0]	Several days [1]	Over half the days [2]	Nearly every day [3]
• Not being able to stop or control worrying?				

Clinic Staff - Please file electronically in the EpicCare PHQ9-A Document Flow sheet

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