

**BRIEF PRIMARY CARE SCREENING
TOOL (ALL EMPIRICALLY
VALIDATED!)**

**1) TWO ITEM SCREEN FOR
DEPRESSION**

**2) THREE ITEM SCREEN FOR
DOMESTIC ABUSE**

**3) TWO ITEM SCREEN FOR
DRUG/ALCOHOL ABUSE**

4) PAIN RATING SCALE

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

2. Do you or your partner work out arguments with:

No difficulty	Some Difficulty	Great difficulty

3. Do you ever feel frightened by what your partner says or does?

Never	Sometimes	Often

4. Has your partner ever abused you emotionally?

Never	Sometimes	Often

5. In the *last year*, have you ever drunk or used drugs more than you meant to?

No	Yes

6. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

No	Yes

7. Are you currently in pain? If yes, how intense is your pain?*

Now	Past Week on Average

HOW TO SCORE

Item 1: If patient answers 2 or 3 on item 1, ask questions 1c through 1i and question 2 on the PHQ. Place PHQ Total and Functioning scores on stamp if screen is positive.

Items 2-4: To score, assign a value of 1 to “often” for items 5 and 6 (Do not score item 4.) Add scores for items 5 and 6. If the total is 1 or 2, explore abuse. This method correctly detected 59% of abused and 100% on non-abused, Spanish-speaking women. See Fogarty, CT & Brown, BB, (2002). Screening for abuse in Spanish-speaking women, JABFP, 15 (2), 101-111.

Items 5-6: If positive on either item, explore substance abuse. A positive response to either or both items detected current substance use disorders in primary care patients aged 18 to 59 years with 80% specificity and sensitivity. See Brown, RL, Leonard, T., Saunders, LA, and Papasouliotis, O. (2001) A two-item conjoint screen for alcohol and other drug problems. Journal of American Board of Family Practice, 14(2), 95-106.

Personal Health Questionnaire –9 (PHQ-9)

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself; or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. 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				
i. Thoughts that you would be better off dead or of hurting yourself in some way				

2. **PHQ Score:** _____ (range: 0-27)

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 (1)
- Somewhat Difficult (2)
- Very Difficult (3)
- Extremely Difficult (4)

PHQ Functioning Difficulties: _____ (1= minimal; 4 = maximal)