

NATIONAL DEPRESSION SCREENING DAY® – COLLEGE SCREENING FORM

1) Age: _____ 2) Sex: _____ (M/F) 3) What year are you in college? <input type="checkbox"/> Freshman <input type="checkbox"/> Senior <input type="checkbox"/> Sophomore <input type="checkbox"/> Graduate Student <input type="checkbox"/> Junior <input type="checkbox"/> Other	5) Do you live: (Check all that apply) <input type="checkbox"/> On Campus <input type="checkbox"/> Alone <input type="checkbox"/> Off Campus <input type="checkbox"/> With Roommates 6) Have you ever been treated for: (Check all that apply) Yes No Depression <input type="checkbox"/> .. <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> .. <input type="checkbox"/> Generalized Anxiety Disorder <input type="checkbox"/> .. <input type="checkbox"/> Post-Traumatic Stress Disorder <input type="checkbox"/> .. <input type="checkbox"/> If yes: Did treatment include medication <input type="checkbox"/> .. <input type="checkbox"/>	7) Have you ever been treated for: (Check all that apply) <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> HIV <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Drug Abuse <input type="checkbox"/> None of the above <input type="checkbox"/> Eating Disorder 8) Have you ever attempted suicide: <input type="checkbox"/> . . <input type="checkbox"/>	Participant No. _____
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THE HANDS® DEPRESSION SCREENING TOOL (The Harvard Department of Psychiatry / National Depression Screening Day® Scale)

Over the past two weeks, how often have you:	None or little of the time	Some of the time	Most of the time	All of the time	Staff Use Only
1. been feeling low in energy, slowed down?					
2. been blaming yourself for things?					
3. had poor appetite?					
4. had difficulty falling asleep, staying asleep?					
5. been feeling hopeless about the future?					
6. been feeling blue?					
7. been feeling no interest in things?					
8. had feelings of worthlessness?					
9. thought about or wanted to commit suicide?					
10. had difficulty concentrating or making decisions?					
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THE MOOD DISORDER QUESTIONNAIRE

Please answer each question as best you can.	YES	NO	Staff Use Only
1. Has there ever been a period of time when you were not your usual self and...			
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>	
...felt much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>	
...you got much less sleep than usual and found you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>	
...you were much more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>	
...thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>	
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>	
...you had much more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>	
...you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>	
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>	
...you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>	
...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	<input type="checkbox"/>	<input type="checkbox"/>	
...spending money got you or your family into trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
Total Score:			
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	<input type="checkbox"/>	<input type="checkbox"/>	
3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please check (✓) one response only. <input type="checkbox"/> No problem <input type="checkbox"/> Minor problem <input type="checkbox"/> Moderate problem <input type="checkbox"/> Serious problem			

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This instrument is designed for screening purposes only and is not to be used as a diagnostic tool.

See reverse for additional screening tools

CLINICIAN: FILL OUT SCREENING RECOMMENDATION SECTION (See box on reverse side)

CARROLL-DAVIDSON GENERALIZED ANXIETY DISORDER SCREEN[©]

■ These questions are to ask about things you may have felt most days in the <u>past six months</u>.	YES	NO	Staff Use Only
1. Most days I feel very nervous.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Most days I worry about lots of things.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Most days I cannot stop worrying.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Most days my worry is hard to control.	<input type="checkbox"/>	<input type="checkbox"/>	
5. I feel restless, keyed up or on edge.	<input type="checkbox"/>	<input type="checkbox"/>	
6. I get tired easily.	<input type="checkbox"/>	<input type="checkbox"/>	
7. I have trouble concentrating.	<input type="checkbox"/>	<input type="checkbox"/>	
8. I am easily annoyed or irritated.	<input type="checkbox"/>	<input type="checkbox"/>	
9. My muscles are tense and tight.	<input type="checkbox"/>	<input type="checkbox"/>	
10. I have trouble sleeping.	<input type="checkbox"/>	<input type="checkbox"/>	
11. Did the things you noted above affect your daily life (home life, or work, or leisure) or cause you a lot of distress?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Were the things you noted above bad enough that you thought about getting help for them?	<input type="checkbox"/>	<input type="checkbox"/>	
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MODIFIED SPRINT (SPRINT-4[©]) PTSD SCREEN

<i>If at any time you have experienced or witnessed a traumatic event, which involves loss of life, serious injury or threat of either:</i> ■ Please respond to these questions about how you have felt most days in the <u>past week</u>.	YES	NO	Staff Use Only
1. Have you been bothered by unwanted memories, nightmares, or reminders of this event?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you been making an effort to avoid thinking or talking about this event, or doing things which remind you of what happened?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you?	<input type="checkbox"/>	<input type="checkbox"/>	
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THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.
PLEASE RETURN THIS FORM TO STAFF FOR SCORING.

SCREENING RECOMMENDATION (TO BE FILLED OUT BY CLINICIAN ONLY)

■ I spoke with the participant and recommended: (Check all that apply)	
Follow-up for: <input type="checkbox"/> Depression	<input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> No follow-up needed
<input type="checkbox"/> Generalized Anxiety Disorder	<input type="checkbox"/> Post-Traumatic Stress Disorder
■ If a Community-Based Site:	■ If a Primary Care Facility:
<input type="checkbox"/> Outpatient Referral	<input type="checkbox"/> Treated in office
<input type="checkbox"/> Inpatient Referral	<input type="checkbox"/> Referred Elsewhere
<input type="checkbox"/> Voluntary	<input type="checkbox"/> Emergency
<input type="checkbox"/> Emergency	