

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 | |