PATIENT STRESS QUESTIONNAIRE

Name:_____

Date: _____ Birth date:_____

Over the **last two weeks**, how often have you been bothered by any of the following problems? *Please circle your answer and check the boxes that apply to you*	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
5. ☐ 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've been moving around a lot more than usual	0	1	2	3
9. ☐ Thoughts that you would be better off dead, or ☐ Hurting yourself in some way	0	1	2	3
ADD COLUMNS				
TOTAL (Add columns)				

1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
ADD COLUMNS				
TOTAL (Add columns)				

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

Please circle your answer	0	1	2	3	4
How often do you have one drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per wee k
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3-4	5-6	7-9	10 or more
How often do you have five or more drinks on one occasion?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
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
How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you 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, 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 that you cut down?	No	Yes, not in the last year		Yes, during the last year	