Patient Label

Name:_____

MRN: _____

Date: _____

KAISER PERMANENTE®

Mental Health Monitoring Tool

Over the past 2 weeks, how often have you been bothered by any of the following problems?	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 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
10. Feeling nervous, anxious or on edge	0	1	2	3
11. Not being able to stop or control worrying	0	1	2	3
12. Have your problems interfered with your work, family or social activities?	0	1	2	3

Please answer these questions about the past year. (If you have changed your drinking or substance use in the past year, please report on your most recent use.)

13. How often do you have a drink containing alcohol?	**Never** 0	**Monthly or less** 1	**2 to 4 times a month** 2		**2 to 3 times a week** 3	**4 or more times a week** 4
14. How many drinks containing alcohol do you have on a typical day when you are drinking?	**None** 0	**1 or 2 drinks** 0	**3 or 4 drinks** 1	**5 or 6 drinks** 2	**7 to 9 drinks** 3	**10 or more drinks** 4
15. How often do you have 6 or more drinks on one occasion?	**Never** 0	**Less than monthly** 1	**Monthly** 2		**Weekly** 3	**Daily or almost daily** 4
16. How often have you used cannabis (THC-containing products)?	**Never** 0	**Less than monthly** 1	**Monthly** 2		**Weekly** 3	**Daily or almost daily** 4
17. How often have you used an illegal drug (not cannabis) or used a prescription medication for non-medical reasons?	**Never** 0	**Less than monthly** 1	**Monthly** 2		**Weekly** 3	**Daily or almost daily** 4
18. Do you have access to guns?			Yes		No	

Your Care Team may ask you to complete these additional questions to help guide your health care. Please wait to complete this section.

Please answer these questions about the past month.	YES	NO
1. During the past month, have you wished you were dead or wished you could go to sleep and not wake up?		
2. During the past month, have you actually had any thoughts of killing yourself?		
3. During the past month, have you been thinking about how you might kill yourself?		
4. During the past month, have you had some intention of acting on those suicidal thoughts?		
5. During the past month, have you worked out some or all of the details of how to kill yourself?		
6. If YES to #5, do you intend to carry out this plan?		
7. Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
8. If YES to #7, how long ago did you do any of these? ☐ Over a year ago? ☐ Between three months and a year ago? ☐ Within the last three months?		