**DARWEN HEALTHCARE NEW PATIENT QUESTIONNAURE (Age 5 yr and over)**

**PLEASE COMPLETE ALL SECTIONS (TO AVOID DELAYS IN THE REGISTRATION PROCESS)**

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| --- | --- | --- | --- |
| **Full name** |  | **Mr/Mrs/Ms/Miss/Master** |  |
| **Date of Birth** |  | **Sex** | **male/female** |
| **Home Telephone No.** |  | **Ethnic group** |  |
| **Mobile Telephone No.** |  | **Language spoken (Do you required an interpreter?)** |  |
| **Work Telephone No.** |  | **Height** |  |
| **Email address** |  | **Weight** |  |
| **Allergies/Intolerances** |  | **Occupation** |  |
| **Have you ever served in the British Armed Services?** | **Yes** | **No** |
| **Have you moved to England from Abroad?** | **Yes** | **No** |
| **Women age 25y to 64y only: date of last cervical smear & result**  |  |

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| **If you are currently taking medications please bring your re-order form from your previous practice or pharmacy. The practice has adopted the Electronic Prescribing Service please advise your preferred pharmacy.** |
| **Nominated Pharmacy** |  |

**A Carer is someone who provides Care on a regular and UNPAID basis for an elderly, ill or disabled relative or friend.**

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| **Are you area carer? YES / NO** |
| **If YES, who do you care for** |
| **What is their relationship to you?** |

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| **Does somebody care for you?** |
| **If so, who cares for you?** |
| **What is their relationship to you?** |
| **What is their telephone number? Daytime: Mobile:** |
| **Do you give your consent for the Practice to discuss any relevant medical information when appropriate with the above carer?****Signature: Date:** |

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| --- | --- | --- | --- | --- |
| **SMOKING STATUS** | **Please tick** | **Amount smoked** | **Date stopped smoking** | **If you are interested in stopping smoking: Please ask at reception or see our website www.darwenhealthcare.co.uk** |
| **Ex-smoker** |  |  |  |
| **Smoker** |  |  |  |
| **Never smoked** |  |  |
|  |
| **ALCOHOL INTAKE - Please tick the boxes that apply to you and add up the points to find your total** |
| **MEN: How often do you have EIGHT or more drinks on one occasion?****WOMEN: How often do you have SIX or more drinks on one occasion?** | **Never****⁭ 0 points** | **Less than monthly****⁭ 1 point** | **Monthly****⁭ 2 points** | **Weekly****⁭ 3 points** | **Daily or almost daily****4 points** |
| **How often during the last year have you been unable to remember what happened the night before because you had been drinking?**  | **Never****⁭ 0 points** | **Less than monthly****⁭ 1 point** | **Monthly****⁭ 2 points** | **Weekly****⁭ 3 points** | **Daily or almost daily****⁭ 4 points** |
| **How often during the last year have you failed to do what was normally expected of you because of drinking?**  | **Never****⁭ 0 points** | **Less than monthly****⁭ 1 point** | **Monthly****⁭ 2 points** | **Weekly****⁭ 3 points** | **Daily or almost daily****⁭ 4 points** |
| **In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?** | **No****⁭ 0 points** |  | **Yes on one occasion****⁭ 2 points** |  | **Yes on more than one occasion****⁭ 4 points** |
| **Total for each column** |  |  |  |  |  |
| **Add all the columns together for your total score** | **\*** |  |

**\*If you have scored 3 or more please complete the next 3 questionnaires in addition – thank you.**

**AUDIT ACOHOL QUESTIONNAIRE**

|  |  |  |
| --- | --- | --- |
| **QUESTIONS** | **Scoring System** | **YOUR****SCORE** |
| **0** | **1** | **2** | **3** | **4** |
| **How often do you have a drink containing alcohol?** | **Never** | **Monthly or less** | **2-4 times per month** | **2-3 times per week** | **4+ times per week** |  |
| **How many units of alcohol do you drink on a typical day when you are drinking?** | **1-2** | **3-4** | **5-6** | **7-9** | **10+** |  |
| **How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?**  | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |  |
| **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 your drinking?** | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |  |
| **How often during the last year have you needed an alcoholic 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 somebody else been injured as a result of your drinking?** | **No** |  | **Yes, but not in the last year** |  | **Yes, during the year** |  |

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| **TOTAL SCORE** |
|  |

**SCORING: 0-7 lower risk, 8-15 increasing risk, 16-19 higher risk, 20 or more possible dependence**

**If your score is 8 – 19: Advice regarding your alcohol intake can be found on the ‘NHS Choices’ website** [**https://www.nhs.uk/livewell/alcohol/Pages/Alcoholhome.aspx**](https://www.nhs.uk/livewell/alcohol/Pages/Alcoholhome.aspx) **, or alternatively, make an appointment with one of our healthcare assistants for a well person check.**

**If your score is 20+: Please make a routine appointment with your GP.**

**Generalized Anxiety Disorder 7-item (GAD-7) scale**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the last 2 weeks, how often have you been****bothered by the following problems?** *(Please circle to indicate you answer)*  | **Not at all sure** | **Several days** | **Over half the days** | **Nearly every day** |
| **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's 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** |
| *For office coding to patient record:* |  |  |  |  |

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| --- |
| **TOTAL SCORE** |
| /21 |

If you checked off any problems, how difficult have these made it for you to do your work, take

care of things at home, or get along with other people?

Not difficult at all \_\_\_\_\_\_\_\_\_\_

Somewhat difficult \_\_\_\_\_\_\_\_\_

Very difficult \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Extremely difficult \_\_\_\_\_\_\_\_\_\_

 **Patient Health Questionnaire-9 (PHQ9)**

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| --- | --- | --- | --- | --- |
| **Over the last 2 weeks, how often have you been****bothered by any of the following problems?** *(Please circle to indicate you answer)*  | **Not at all sure** | **Several days** | **Over half the days** | **Nearly every day** |
| **Little interest or pleasure in doing things**  | **0** | **1** | **2** | **3** |
| **Feeling down, depressed, or hopeless** | **0** | **1** | **2** | **3** |
| **Trouble falling or staying asleep, or sleeping too much**  | **0** | **1** | **2** | **3** |
| **Feeling tired or having little energy**  | **0** | **1** | **2** | **3** |
| **Poor appetite or overeating**  | **0** | **1** | **2** | **3** |
| **Feeling bad about yourself, or that you are a failure, or have let yourself or your family down**  | **0** | **1** | **2** | **3** |
| **Trouble concentrating on things, such as reading the newspaper or watching television**  | **0** | **1** | **2** | **3** |
| **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** |
| **Thoughts that you would be better off dead or of hurting yourself in some way** | **0** | **1** | **2** | **3** |
| *For office coding to patient record:* |  |  |  |  |

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| **TOTAL SCORE** |
| /27 |

If you checked off any problems, how difficult have these made it for you to do your work, take

care of things at home, or get along with other people?

Not difficult at all \_\_\_\_\_\_\_\_\_\_

Somewhat difficult \_\_\_\_\_\_\_\_\_

Very difficult \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Extremely difficult \_\_\_\_\_\_\_\_\_\_