

Adult Wellbeing – Scoring Guide

| Over the last 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. Feeling nervous, anxious, or on edge   | 0          | 1            | 2                       | 3                |
| 4. Not being able to stop or control worrying   | 0          | 1            | 2                       | 3                |

**1,2. If questions 1 &/or 2 are 2 or 3, administer the Patient Health Questionnaire (PHQ-9).  
3,4. If questions 3 &/or 4 are 2 or 3, administer the Generalized Anxiety Disorder (GAD-7) Scale.**

| Has there ever been a period of time when you were not your usual self and...  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| 5. ... you felt so good or full of energy that other people thought you were not your normal self or it got you into trouble? (e.g., unable to sleep, over-spending, gambling) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. ...you were so irritable that you shouted at people or started fights or arguments?   | <input type="checkbox"/> | <input type="checkbox"/> |

**5,6. If questions 5 and/or 6 are "Yes," administer the Mood Disorders Questionnaire (MDQ).**

| During the past year:  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| 7. Have you had 4 or more drinks (women) / 5 or more drinks (men) in a day?            | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you used an illegal drug or used a prescription drug for a non-medical reason? | <input type="checkbox"/> | <input type="checkbox"/> |






**7,8. If questions 7 and/or 8 are "Yes," administer the AC-OK.**

| Over the last 4 weeks:  | No                       | Yes                      |
|---|--------------------------|--------------------------|
| 9. Have you had a problem with sleep more than occasionally? (This could include: trouble falling asleep, waking frequently, or sleeping too much.) | <input type="checkbox"/> | <input type="checkbox"/> |

**9. If the answer to question 9 is "Yes", further assessment of this person's sleep pattern is warranted.**

DAILY ACTIVITIES






How much difficulty have you had doing your usual activities or task, both inside and outside the house because of your physical and emotional health?

|                            |   |   |
|----------------------------|---|---|
| No difficulty at all       |  | 1 |
| A little bit of difficulty |  | 2 |
| Some difficulty            |  | 3 |
| Much difficulty            |  | 4 |
| Could not do               |  | 5 |

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SOCIAL ACTIVITIES





Has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

|             |   |   |
|-------------|---|---|
| Not at all  |  | 1 |
| Slightly    |  | 2 |
| Moderately  |  | 3 |
| Quite a bit |  | 4 |
| Extremely   |  | 5 |

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OVERALL HEALTH

How would you rate your health in general?

|           |   |   |
|-----------|---|---|
| Excellent |  | 1 |
| Very good |  | 2 |
| Good      |  | 3 |
| Fair      |  | 4 |
| Poor      |  | 5 |

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**10. A score of '4' or '5' on any of these suggests a functional impairment that should be assessed further.**