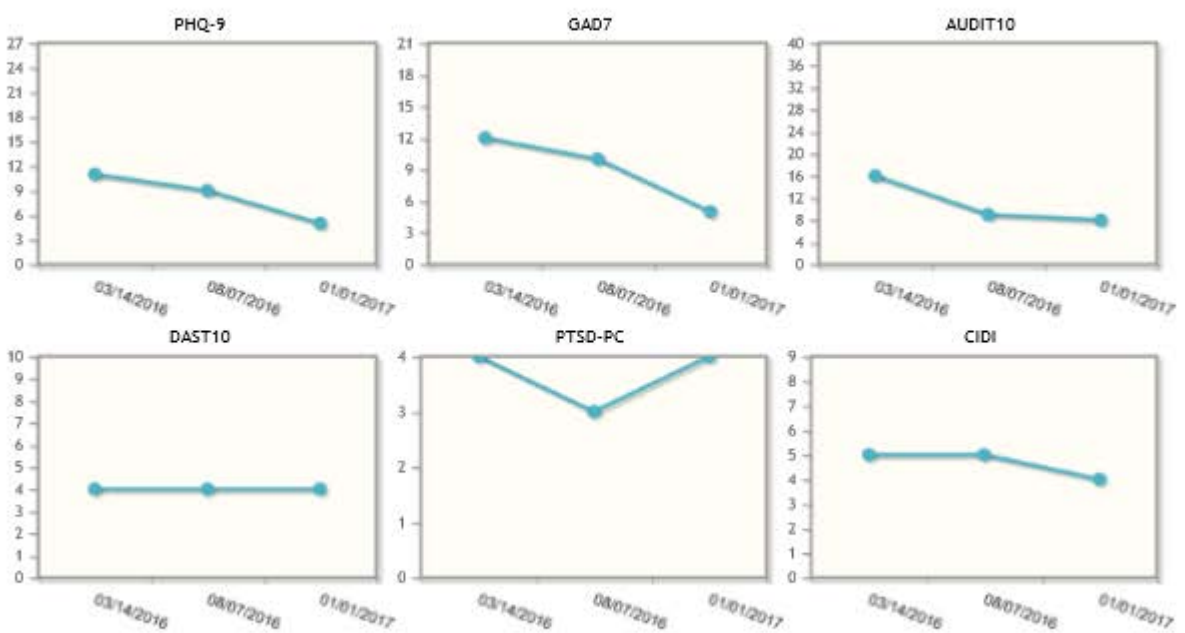
Report: IBH Master Report
Patient ID: asdf
Date: 1/1/2017 12:00:00PM

Results

Survey	Score	Score Interpretation
PHQ-9 -Suicidality	5 Positive	Mild
GAD-7	5	Mild anxiety
AUDIT-10	8	Medium
DAST-10	4	Moderate level
PTSD-PC	4	Positive
CIDI	4	Very low risk (less than 5%) 0-4 questions with positive endorsement

Recommendations:

PHQ-9 (Depression)	**Mild**
GAD-7 (Anxiety)	**Mild anxiety**
AUDIT-10	**Medium**
DAST-10	**Moderate level**
PTSD-PC	**Positive**



Item		Response	(value)
Depression Items (PHQ)		**Mild**	**(5)**
1.	Little interest or pleasure in doing things	Several days	(1)
2.	Feeling down, depressed, or hopeless	Several days	(1)
3.	Trouble falling or staying asleep, or sleeping too much	Not at all	(0)
4.	Feeling tired or having little energy	Not at all	(0)
5.	Poor appetite or overeating	Several days	(1)
6.	Feeling bad about yourself	Not at all	(0)
7.	Trouble concentrating on things	Not at all	(0)
8.	Moving or speaking so slowly (Or the opposite)	Not at all	(0)
9.	Thoughts that you would be better off dead, or hurting yourself in some way	**More than half the days**	**(2)**
10.	If you are experiencing any of the previous problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Somewhat Difficult	
Anxiety Items (GAD)		**Mild anxiety**	**(5)**
1.	Feeling nervous, anxious or on edge	Several days	(1)
2.	Not being able to stop or control worrying	Not at all	(0)
3.	Worrying too much about different things	More than half the days	(2)
4.	Trouble relaxing	Several days	(1)
5.	Being so restless that it is hard to sit still	Not at all	(0)
6.	Becoming easily annoyed or irritable	Not at all	(0)
7.	Feeling afraid as if something awful might happen	Several days	(1)
Alcohol Use Items (AUDIT)		**Medium**	**(8)**
1.	How often do you have a drink containing alcohol?	Monthly	(1)
2.	Amount of drinks on a typical day:	N/A	(0)
3.	How often do you have six or more drinks on one occasion?	Monthly	(2)
4.	Not able to stop drinking	Less than monthly	(1)
5.	Failed to meet normal expectations	Less than monthly	(1)
6.	Needed a morning drink	Monthly	(2)
7.	Guilty/remorseful	Less than monthly	(1)
8.	Loss of memory due to drinking	Never	(0)
9.	Have you or has someone else been injured as a result of your drinking?	No	(0)
10.	Relative/friend/doctor, etc - concerned/cut down drinking	No	(0)
Drug Use Items (DAST)		**Moderate level**	**(4)**
1.	Have you used drugs other than those required for medical reasons?	Yes	(1)
3.	Do you use more than one drug at a time?	No	(0)
4.	Are you always able to stop using drugs when you want to?	Yes	(0)
5.	Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	(1)
6.	Do you ever feel bad about your drug abuse?	Yes	(1)
7.	Does your spouse (or parents) ever complain about your involvement with drugs?	No	(0)
8.	Have you ever neglected your family or missed work because of your use of drugs?	No	(0)
9.	Have you engaged in illegal activities in order to obtain drugs?	No	(0)
10.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	Yes	(1)
11.	Have you had medical problems as a result of your drug use?	No	(0)

PTSD-PC		Positive	(4)
1.	In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you: Have had nightmares about it or thought about it when you did not want to?	Yes	(1)
2.	In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you: Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	(1)
3.	In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you: Were constantly on guard, watchful, or easily startled?	Yes	(1)
4.	In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you: Felt numb or detached from others, activities, or your surroundings?	Yes	(1)

PCL-PTSD			()

CIDI		Very low risk (less than 5%) 0-4 questions with positive endorsement	(4)
1.	Were you so irritable that you either started arguments, shouted at people, or hit people?	Yes	(1)
2.	Did you become so restless or fidgety that you paced up and down or couldn't stand still?	Yes	(1)
3.	Did you do anything else that wasn't usual for you--like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?	No	(0)
4.	Did you try to do things that were impossible to do, like taking on large amounts of work?	Yes	(1)
5.	Did you constantly keep changing your plans or activities?	Yes	(1)
6.	Did you find it hard to keep your mind on what you were doing?	No	(0)
7.	Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn't keep track of them?	No	(0)
8.	Did you sleep far less than usual and still not get tired or sleepy?	No	(0)
9.	Did you spend so much more money than usual that it caused you to have financial trouble?	No	(0)