Alliance Behavioral Medicine, LLC
Ramzi Nassar, M.D.

Patient Name________________________________ Date of Birth____________________________
Date_______________________________________ Chart Number____________________________

## CARROLL-DAVIDSON GENERALIZED ANXIETY DISORDER SCREEN

| During the past six months: | Yes | No |
|---|---|---|
| 1. Most days I feel very nervous. | | |
| 2. Most days I worry about lots of things. | | |
| 3. Most days I cannot stop worrying. | | |
| 4. Most days my worry is hard to control. | | |
| 5. I feel restless, keyed up or on edge. | | |
| 6. I get tired easily. | | |
| 7. I have trouble concentrating. | | |
| 8. I am easily annoyed or irritated. | | |
| 9. My muscles are tense and tight. | | |
| 10. I have trouble sleeping. | | |
| 11. Did the things noted above affect your daily life (home life, work, or leisure) or cause distress? | | |
| 12. Were the things you noted above bad enough that you thought about getting help for them? | | |

## MODIFIED SPRINT (SPRINT-4) PTSD SCREEN

| *Have you ever experienced or witnessed a traumatic event, which involved loss of life, serious injury or threat of either:* If yes, during the past week: | Yes | No |
|---|---|---|
| 1. Have you been bothered by unwanted memories, nightmares, or reminders of this event? | | |
| 2. Have you been making an effort to avoid thinking or talking about this event, or doing things which remind you of what happened? | | |
| 3. Have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings? | | |
| 4. Have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you? | | |