Place Patient Sticker Here

 **How many weeks are you pregnant?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check off the box next that **describes how you have felt in the PAST 7 DAYS**.

**1. I have been able to laugh and see the funny side of things**

* As much as I always could
* Not quite so much now
* Definitely not so much now
* Not at all

**2. I have looked forward with enjoyment to things**

* As much as I ever did
* Rather less than I used to
* Definitely less than I used to
* Hardly at all

**3. \*I have blamed myself unnecessarily when things went wrong**

* Yes, most of the time
* Yes, some of the time
* Not very often
* No, never

**4. I have been anxious or worried for no good reason**

* No, not at all
* Hardly ever
* Yes, sometimes
* Yes, very often

**5. \*I have felt scared or panicky for no very good reason**

* Yes, quite a lot
* Yes, sometimes
* No, not much
* No, not at all

**6. \*Things have been getting on top of me (feeling overwhelmed)**

* Yes, most of the time I haven’t been able to cope at all
* Yes, sometimes I haven’t been coping as well as usual
* No, most of the time I coped quite well
* No, I have been coping as well as ever

**7. \*I have been so unhappy that I have had difficulty sleeping**

* Yes, most of the time
* Yes, sometimes
* Not very often
* No, not at all

**8. \*I have felt sad or miserable**

* Yes, most of the time
* Yes, quite often
* Not very often
* No, not at all

**9. \*I have been so unhappy that I have been crying**

* Yes, most of the time
* Yes, quite often
* Only occasionally
* No, never

**10. \*The thought of harming myself has occurred to me**

* Yes, quite often
* Sometimes
* Hardly ever
* Never

**Depending on your answers, you might benefit from some support. Are you interested in:**

\_\_\_ Supportive Counseling

\_\_\_ Meeting with a psychiatrist to learn more

\_\_\_ Stress Management Support Group

\_\_\_ Need more time to think about it

\_\_\_ I don’t need support

**Is it okay for us to reach out to you? YES / NO Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Contact us (**617-414-2281**) to learn more about mental health support during & after pregnancy

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Please fill this out and give to the medical assistant when he/she takes you to the exam room. Your answers will help your care team take better care of your health and connect you with resources. Thank you!

**Institute for Health and Recovery**

5Ps SUD Screen

By “alcohol,” we mean beer, wine, wine coolers, or liquor. By “drugs” we mean marijuana, prescription medications, and illicit substances (heroin, cocaine, ecstasy, methamphetamines, PCP, LSD, etc).

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Yes No

**9) Comments?**

Yes No

Yes No

Yes No

Yes No

Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with people, or take care of things at home?

**5) Emotional Health**

Are you feeling at all unsafe in any way in your relationship with your current partner?

Yes No

Yes No

Yes No

**8) Present**

Have you smoked any cigarettes in the past three months?

In the past month, have you had any alcohol or used other drugs?

If yes:

7a) How many days per month do you drink? \_\_\_\_\_

7b) How many drinks on any given day? \_\_\_\_

7c) How often did you have 4 or more drinks per day in the last month? \_\_\_\_

**7) Present**

In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?

**6) Past**

**4) Violence**

Does your partner have a problem with alcohol or other drug use?

**3) Partner**

Do any of your friends have a problem with alcohol or other drug use?

**2) Peers**

Do/Did any of your parents/caregivers have a problem with alcohol or other drug use?

**1) Parents/Caregivers**