Screening Resources

Companion to the Intake Packet · Home · Simply Well · Compass Medical Clinic

This packet contains six brief screening tools your care team uses to understand you fully. Please complete these at home before your first visit and bring them with you.

These focus on factual, everyday health information. A separate short packet with more personal questions will be given to you in the waiting room at your first visit.

HOW TO COMPLETE

Circle the response that best fits you. There are no right or wrong answers. If a question does not apply, mark whatever comes closest — or leave it blank and note it for your care team.

Time to complete: approximately 8–10 minutes.

WHAT'S INSIDE

1	**AUDIT-C**	*Alcohol use · 3 items*
2	**STOP-Bang**	*Sleep apnea risk · 8 items*
3	**PAR-Q+**	*Physical activity readiness · 7 items*
4	**Connection**	*Loneliness and support · 3 items + 2 questions*
5	**ASRS-6**	*Adult ADHD screener · 6 items*
6	**PSS-4**	*Perceived stress · 4 items*

1 · AUDIT-C

Alcohol Use Disorders Identification Test — Consumption

These three questions ask about your typical alcohol use.

1. How often do you have a drink containing alcohol?

○ Never (0)	○ Monthly or less (1)	○ 2–4 times a month (2)	○ 2–3 times a week (3)	○ 4+ times a week (4)

2. How many standard drinks containing alcohol do you have on a typical day when drinking?

○ 1 or 2 (0)	○ 3 or 4 (1)	○ 5 or 6 (2)	○ 7 to 9 (3)	○ 10 or more (4)

3. How often do you have 6 or more drinks on one occasion?

○ Never (0)	○ Less than monthly (1)	○ Monthly (2)	○ Weekly (3)	○ Daily or almost daily (4)

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2 · STOP-Bang

Sleep Apnea Risk Screener

These questions help assess your risk for obstructive sleep apnea. Answer honestly — some items are things others may have noticed about you.

If you have sleep apnea, skip this one.

QUESTION	YES	NO
1. Snoring loudly? (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)	○	○
2. Tired? Do you often feel tired, fatigued, or sleepy during the daytime?	○	○
3. Observed? Has anyone observed you stop breathing, choking, or gasping during your sleep?	○	○
4. Pressure? Do you have or are you being treated for high blood pressure?	○	○
5. BMI more than 35 kg/m²?	○	○
6. Age older than 50 years?	○	○
7. Neck circumference greater than 16 inches (40 cm)?	○	○
8. Gender = male?	○	○

3 · PAR-Q+

Physical Activity Readiness Questionnaire · General Health Questions

This questionnaire helps identify whether you should check with your doctor before becoming more physically active. Please read each question carefully and answer honestly.

QUESTION	YES	NO
1. Has your doctor ever said that you have a heart condition or high blood pressure?	○	○
2. Do you feel pain in your chest at rest, during your daily activities of living, or when you do physical activity?	○	○
3. Do you lose balance because of dizziness, or have you lost consciousness in the last 12 months? (Please answer NO if your dizziness was associated with over-breathing including during vigorous exercise)	○	○
4. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?	○	○
5. Are you currently taking prescribed medications for a chronic medical condition?	○	○
6. Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue problem that could be made worse by becoming more physically active?	○	○
7. Has your doctor ever said that you should only do medically supervised physical activity?	○	○

4 · Connection

Loneliness and Support

These questions ask about connection — how connected you feel lately, and who is in your corner.

ITEM	Hardly Ever *1*	Some of the Time *2*	Often *3*
1. How often do you feel that you lack companionship?	○	○	○
2. How often do you feel left out?	○	○	○
3. How often do you feel isolated from others?	○	○	○

MY SUPPORT

Who do you turn to when things get hard?

Who is most likely to support the changes you are making?

5 · ASRS-v1.1

Adult ADHD Self-Report Scale · 6-Item Screener

How often have you experienced the following in the past 6 months?

ITEM	Never *0*	Rarely *1*	Sometimes *2*	Often *3*	Very Often *4*
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	○	○	○	○	○
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	○	○	○	○	○
3. How often do you have problems remembering appointments or obligations?	○	○	○	○	○
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	○	○	○	○	○
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	○	○	○	○	○
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	○	○	○	○	○

6 · PSS-4

Perceived Stress Scale · Short Form

The questions in this scale ask you about your feelings and thoughts during the last month. Indicate how often you felt or thought a certain way.

ITEM	Never *0*	Almost Never *1*	Sometimes *2*	Fairly Often *3*	Very Often *4*
1. In the last month, how often have you felt that you were unable to control the important things in your life?	○	○	○	○	○
2. In the last month, how often have you felt confident about your ability to handle your personal problems?	○	○	○	○	○
3. In the last month, how often have you felt that things were going your way?	○	○	○	○	○
4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

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