For provider use only		
☐ Intake	☐ 3Mo Fu	☐ 6Mo Fu

Post Deployment Clinical Assessment Tool

PRIVACY ACT STATEMENT –Post Deployment Clinical Assessment Tool

AUTHORITY: 5 U.S.C. 301; and Executive Order 9397

PRINCIPAL PURPOSE: The Post Deployment Clinical Assessment Tool (PDCAT) is being administered to assist in providing appropriate care for you and/or your family in relation to deployments, bio-terrorism, and other threats. This tool will also assist in planning to provide better care to our beneficiaries in the future. The PDCAT will be used by your health-care manager in coordination with your primary care manager to tailor optimum care for you.

ROUTINE USES: None

DISCLOSURE: Voluntary. Failure to respond will not result in any penalty. However, maximum participation is encouraged so that data will be complete and representative. Your PDCAT form will be treated as confidential.

I HAVE READ THE ABOVE AND UNDERSTAND THE INFORMATION.

____

Print Name

____

Signature

PRIVACY ACT STATEMENT

Date Completed

☐☐ / ☐☐ / ☐☐

year / month / day

……………………………………………………………………………………………

Patient Identification

INSTRUCTIONS:

Please fill out this PDCAT as completely as possible. It is important to answer every question you can, but if you feel uncomfortable with any question feel free to skip to the next question.

Please print all written answers clearly. Place an “X” in each of the appropriate boxes. If you have any questions, please ask your healthcare provider for assistance.

This information will be used to assist with your care. The healthcare provider administering this PDCAT may contact you or your doctor as needed. With your permission, we may contact you again in the future for clinical purposes.

The information you provide will be treated in accordance with the privacy act. No information about you will be released or made public. We may share this information with your doctor or other providers to assist in your care. Reports may be made from the data, for the purpose of improving quality of care, but no one will be identifiable in these reports.

Patient Information:

Name: ____

Last **First** **MI**

Your Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

What is your current mailing address (Where you would like to be contacted if necessary)?

____

____

____

What is the best phone number to reach you? (☐☐☐) ☐☐☐ - ☐☐☐☐

What is the best E-mail address to reach you? ______________________

What Medical Treatment Facility (MTF) or hospital ward is providing your main care?

____

Post Deployment Clinical Assessment Tool

	NO	YES	MAYBE
1. Is your problem today related to deployment, either yours or your sponsors?	☐	☐	☐
2. Is your problem today related to participation in combat or war,? Either yours or your sponsors?	☐	☐	☐
3. Is your problem today related to homeland security or terrorism?	☐	☐	☐

4. During the PAST MONTH, how OFTEN have you been bothered by:

	Not Bothered	**Bothered A Little**	**Bothered A Lot**
a. stomach pain?	☐	☐	☐
b. back pain?	☐	☐	☐
c. pain in your arms, legs or joints (knees, hips, etc.)?	☐	☐	☐
d. menstrual cramps or other problems with your period?	☐	☐	☐
e. pain or problems during sexual intercourse?	☐	☐	☐
f. headaches?	☐	☐	☐
g. chest pain?	☐	☐	☐
h. dizziness?	☐	☐	☐
i. fainting spells?	☐	☐	☐
j. feeling your heart pound or race?	☐	☐	☐
k. shortness of breath?	☐	☐	☐
l. constipation, loose bowels, or diarrhea?	☐	☐	☐

m. nausea, gas or indigestion? ☐ ☐ ☐

5. 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**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed – Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐

i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

	NO	YES
6. In the LAST 4 WEEKS, have you had an anxiety attack – suddenly feeling fear or panic?	☐	☐

If you checked "NO", go to Question 8

	NO	YES
a. Has this ever happened before (an anxiety attack-suddenly feeling fear or panic)?	☐	☐
b. Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
c. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐

7. Think about your last bad anxiety attack.	NO	YES
a. Were you short of breath?	☐	☐
b. Did your heart race, pound, or skip?	☐	☐
c. Did you have chest pain or pressure?	☐	☐
d. Did you sweat?	☐	☐
e. Did you feel as if you were choking?	☐	☐
f. Did you have hot flashes or chills?	☐	☐
g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	☐	☐
h. Did you feel dizzy, unsteady, or faint?	☐	☐
i. Did you have tingling or numbness in parts of your body?	☐	☐
j. Did you tremble or shake?	☐	☐
k. Were you afraid you were dying?	☐	☐

8. **Over the LAST 4 WEEKS, how often have you been bothered by any of the following problems?**

	Not at all bothered	Several days	More than half the days
a. Feeling nervous, anxious, on edge, or worrying a lot about different things	☐	☐	☐
b. Feeling restless so that it is hard to sit still	☐	☐	☐
c. Getting tired very easily	☐	☐	☐
d. Muscle tension, aches, or soreness	☐	☐	☐
e. Trouble falling asleep or staying asleep	☐	☐	☐
f. Trouble concentrating on things, such as reading a book or watching TV	☐	☐	☐
g. Becoming easily annoyed or irritable	☐	☐	☐

9. **Did you EVER in your lifetime have an experience(s) that caused you to think that you would be injured or killed (e.g. witnessing or experiencing serious accident or illness, threatened with a weapon, assaulted, natural disaster)? (Mark all that apply).**

NO	YES as child	YES as adult	YES during deployment
☐	☐	☐	☐

10. **Which of the following have you experienced?**	**YES In the past year**	**YES More than a year ago**	**NEVER**
a. Being in or witnessing an accident causing serious injury or death	☐	☐	☐
b. Clearing/searching homes, buildings, caves or bunkers	☐	☐	☐
c. Questioning detainees or prisoners	☐	☐	☐
d. Being combat wounded or injured	☐	☐	☐
e. Knowing someone seriously injured or killed	☐	☐	☐

Which of the following have you experienced?	YES In the past year	YES More than a year ago	NEVER
f. Physical ambush or assault	☐	☐	☐
g. Being shot at	☐	☐	☐
h. Seeing, handling, or smelling dead bodies or body parts	☐	☐	☐
i. Seeing dead or seriously injured Americans	☐	☐	☐
j. Shooting or directing fire at others	☐	☐	☐
k. Witnessing brutality towards detainees or prisoners	☐	☐	☐
l. Seeing innocent victims of war	☐	☐	☐
m. Being in a chemical or biological attack	☐	☐	☐

Think about the serious event or events that caused you to fear you would be injured or killed. Questions 11 through 14 refer to symptoms or problems you may have recently noticed IN RESPONSE TO THESE SERIOUS EVENTS.

11. IN THE PAST 30 DAYS how much have you been troubled by repeated disturbing memories or dreams?

Not at all	A Little Bit	Moderately	Quite A Bit	Extremely
☐	☐	☐	☐	☐

12. IN THE PAST 30 DAYS how much have you been feeling emotionally numb or unable to have loving feelings for those close to you?

Not at all	A Little Bit	Moderately	Quite A Bit	Extremely
☐	☐	☐	☐	☐

13. IN THE PAST 30 DAYS how much have you avoided thinking or having feelings about the event or events?

Not at all	A Little Bit	Moderately	Quite A Bit	Extremely
☐	☐	☐	☐	☐

14. IN THE PAST 30 DAYS how much have you been feeling jumpy or easily startled?

Not at all	A Little Bit	Moderately	Quite A Bit	Extremely
☐	☐	☐	☐	☐

15. Do you ever drink alcohol (including beer or wine)?	**NO**	**YES**
	☐	☐

If you checked NO go to question # 17

16. Have any of the following happened to you more than once in the last 6 months?

	NO	**YES**
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health	☐	☐
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities	☐	☐
c. You missed or were late for work, school, or other activities because you were drinking or hung over	☐	☐
d. You had a problem getting along with other people while you were drinking	☐	☐
e. You drove a car after having several drinks or after drinking too much	☐	☐

17. If you checked off any problems on questions 4-16, 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?

Not difficult	Somewhat	Very	Extremely
☐	☐	☐	☐

18. Would you say that your health in general is:

Excellent	Very Good	Good	Fair	Poor
☐	☐	☐	☐	☐

19. Now thinking about your physical health, which includes physical illness and injury, for how many days during the PAST 30 DAYS was your physical health not good?

Days in past 30

20. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the PAST 30 DAYS was your mental health not good?

Days in past 30

21. DURING THE PAST 30 DAYS for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

Days in past 30

22. DURING THE PAST 30 DAYS for about how many days did poor physical or mental health keep you from going to work?

Days in past 30

23. About how many CLOSE FRIENDS OR RELATIVES do you have that you feel at ease with and can talk to about what is on your mind?

Close friends & relatives

24. Has your doctor ever told you that you have…

	NO	YES
a. Asthma, emphysema or chronic bronchitis (or chronic obstructive pulmonary disease)	☐	☐
b. Hypertension	☐	☐
c. Diabetes	☐	☐
d. Arthritis (including rheumatoid or osteoarthritis)	☐	☐
e. Myocardial infarction, heart attack or heart problems including angina)	☐	☐
f. Depression	☐	☐

25. Do you smoke cigarettes?	No Never	Yes Currently	Smoked in the past
	☐	☐	☐

26. How many times in the last 3 MONTHS have you visited a nurse, physician assistant (PA), or medical doctor (other than a psychiatrist)?

Visits

27. How many times in the last 3 MONTHS have you visited a psychiatrist, psychologist, social worker or other mental health provider?

Visits

28. How many times in the last 3 MONTHS have you received a new or refill prescription medicine?

Fills or refills

☐☐

29. Please rate your OVERALL level of satisfaction with your health care over the past 3 MONTHS.

Excellent	Very Good	Good	Fair	Poor
☐	☐	☐	☐	☐

30. If you have previously met with a care-manager, please rate your OVERALL level of satisfaction with that care manager.

Excellent	Very Good	Good	Fair	Poor
☐	☐	☐	☐	☐

31. What best describes your current marital status?

Married	Divorced	Widowed	Separated	Never Been Married
☐	☐	☐	☐	☐

32. How many years of school have you completed?

Years of school

☐☐

33. Which of the following best describes your current status:

Active Duty	Reserve Component	Retired	Spouse of Service-member	Child of Service-member	Other
☐	☐	☐	☐	☐	☐

33. What branch of military service are you or your sponsor serving in?

Army	Air Force	Navy	Marines	Other
☐	☐	☐	☐	☐

34. What is your current rank (if retired, enter your rank at the time you retired; if spouse, fill in rank of your sponsor)?

Civilian	E1-E4	E5-E6	E7-E9	Warrant Officer	O1-O3	O4-O6	O7 & Above
☐	☐	☐	☐	☐	☐	☐	☐

35. How old are you?

Age in Years

36. What is your sex?

Male	Female
☐	☐

37. What clinic are you visiting today?__________________________

38. How were you referred to the Health Care Manager?

Command referral	Self-referral	Primary Care Provider referral	Other Clinic or Provider referral
☐	☐	☐	☐

39. If you selected "other clinic or provider"' please specify the

Clinic or Provider____

Interviewer Comment Page.

Summary

Preliminary Indicators			
Som Dis:	**Maj Dep Syn:**	**Other Dep Syn:**	**Panic Syn:**
PTSD:	**Other Anx Dis**	**Alcohol Abu:**	

The purpose of the preliminary indicators is to alert the Healthcare-Professional administering the PDCAT of the possibility that a patient is showing symptoms associated with a particular disorder. The existence of a preliminary indicator is not a criteria for assigning a clinical diagnosis, rather it is an indication to the provider of the need for further assessment or referral.

Somatoform Disorder *if at least 3 of #4a-m bother the patient "a lot" and lack an adequate biological explanation.*

Somatic Symptom Severity Scale[1] The PHQ-15 is a somatic symptom subscale derived from the full PHQ. It inquires about 15 somatic symptom clusters that account for more than 90% of the physical complaints reported in the outpatient setting. Thirteen (question 4a-m) of the PHQ-15 somatic symptoms questions are from the PHQ somatic symptom module, in which the patients are asked to rate their severity of each symptom as "0" for "not bothered at all", "1" for "bothered a little", & "2" for " bothered a lot".

Remaining 2 questions (5c-d) in the PHQ-15 are from the PHQ depression module, in which the responses are coded as "0" for "not at all", "1" for "several days", & "2"for "more than half the days" or "nearly everyday". *Scores for questions 4a-m & 5c-d, are added and the Somatic Symptom Severity is categorized as "Minimal" (PQ-15 score = 0-4), "Low" (score = 5-9), "Medium" (score = 10-14) & "High" (score 15-30).*

Major Depressive Syndrome *if #5a or b and 5 or more of #5a-i are at least "more than half the days" (count #2i if present at all).*

Depression Severity[2] PHQ-9 is the 9-item depression module (questions 5a-i) from the full PHQ. As a severity measure, the PHQ-9 score can range from 0-27, since each of the 9 items can be scored as 0 "not at all", 1 "several days", 2 "more than half the days" & 3 nearly every day". *Scores for questions 5a-i are added and the Depression Severity is categorized as "Minimal" (score = 0-4), "Mild" (score = 5-9), "Moderate" (score = 10-14), "Moderately severe (score = 15-19) & "High/Severe" (score 20-27).*

Other Depressive Syndrome *if #5a or b and 2, 3, or 4 of #5a-i are at least "more than half the days".*

NOTE: The diagnosis of **Major Depressive Disorder** requires ruling out normal **bereavement** (mild symptoms, duration less than 2 months), a history of **manic** episode and a **physical disorder, medication or other drug** as the biological cause of the depressive symptoms.

Panic Syndrome if *#6-6c are all "Yes" and 4 or more of #7a-k are "Yes".*

Other Anxiety Syndrome *if #8a and answers to 3 or more of #8b-g are "more than half days".*

NOTE: The diagnoses of Panic Disorder and Other Anxiety Disorder require ruling out a **physical disorder, medication or other drug** as the biological cause of the anxiety symptoms

Alcohol abuse *if any of #16a-e are "Yes".*

PTSD *only if question 9 is "YES" and if 3 or more of questions 11-14 are answered "a little bit", if 2 or more are answered "moderately", or if 1or more is answered "quite a bit/Extremely".*