Full Name:

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| --- | --- | --- | --- | --- |
| **PATIENT HEALTH QUESTIONNAIRE**  **(PHQ-9)** | | | | |
| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** *(Add “****NUMBER****” that corresponds with your answer)* | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** 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 | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

**If you checked off any 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?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Not difficult**  **at all** | **Somewhat**  **difficult** | **Very**  **difficult** | **Extremely difficult** |

Full Name:

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| --- | --- | --- | --- | --- |
| **PATIENT HEALTH QUESTIONNAIRE**  **(GAD-7)** | | | | |
| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** *(Add “****NUMBER****” that corresponds with your answer)* | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| **1.** Feeling nervous, anxious, or on edge. | 0 | 1 | 2 | 3 |
| **2.** Not being able to stop or control worrying. | 0 | 1 | 2 | 3 |
| **3.** Worrying too much about different things. | 0 | 1 | 2 | 3 |
| **4.** Trouble relaxing. | 0 | 1 | 2 | 3 |
| **5.** Being so restless that it’s hard to sit still. | 0 | 1 | 2 | 3 |
| **6.** Becoming easily annoyed or irritable. | 0 | 1 | 2 | 3 |
| **7.** Feeling afraid as if something awful might happen. | 0 | 1 | 2 | 3 |

**If you checked off any 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?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Not difficult**  **at all** | **Somewhat**  **difficult** | **Very**  **difficult** | **Extremely difficult** |