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?**

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| --- | --- | --- | --- |
|  **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**  |