

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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
<i>Add the score for each column</i>	+	+	+	
Total Score (<i>add your column scores</i>) =				

If you checked off any problems, how difficult have these 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 _____

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate 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	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL:
please refer to accompanying scoring card).

<p>10. If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
--	--

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

PHQ9 Copyright © Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD ® is a trademark of Pfizer Inc.

Ht:

Date:

Wt:

BMI:

THE TEENS VISIT

Development

1. Sex Education
 - It's way past time to talk birds and bees, but keep the conversations going. Answer questions about sex factually, using actual language and terms. If you need an informational book, please ask for one.
 - Talk with your teen about the changes his/her body will undergo during puberty. Prepare your daughter for the onset of menarche and her periods.
 - Talk to your teen about safe sex and the risks of sexually transmitted disease and teen pregnancy.
2. Actively discourage harmful habits like smoking, alcohol, and drugs. Talk with your teen about peer pressure and how to say no, and the real risks of drunk driving.
3. Talk to your teen about social media and online safety, including online bullying and predators. Internet safety should be a regular and reoccurring conversation at the dinner table.

Injury Prevention

1. Teach your teen to **ALWAYS** wear seat belts even if others in the car do not. By this age, buckling up should be an almost automatic reflex.
2. Continued used of protective equipment for high risk activities (HELMETS are cool!)

Good Health Habits and Self Care

1. Continue to maintain a regular bedtime routine. Teens need 8-10 hours a night.
2. Set limits on TV viewing/video games/social media. The cell phone needs a "bed time" and should be charged outside the room. Parents should set an example.
3. Obesity is a significant health threat. If you are worried, PLEASE bring it up at your visit.
4. Be on the lookout for eating disorders in boys and girls. Discuss all forms of healthy eating, both too much and too little. Don't skip breakfast.

Next Visit

Continue yearly visits, which also serve as sports, camp, and college physicals. Some parents come around the birthday. Some come every fall break. It is a good idea to avoid late June until early August for your yearly check. These are especially busy times here at the office.

All Teens need to get the HPV (Gardasil) vaccine. More people will die this year from HPV disease than died yearly from measles before that vaccine came out. It is a "no-brainer" vaccine. 60% of people are infected with HPV. The odds are against you. Get the first one before age 15, and you only need two shots. You'll need three if you start the HPV vaccine after age 15.

Your teen will need a meningitis booster before heading to college.

We see patients up to age 21.

Don't forget to get a flu vaccine.



PARENT-TEEN DRIVING AGREEMENT

I, _____, will drive carefully and cautiously and will be courteous to other drivers, bicyclists, and pedestrians at all times.

I PROMISE.

I promise that I will obey all the rules of the road.

- Always wear a seat belt and make all my passengers buckle up
- Obey all traffic lights, stop signs, other street signs, and road markings
- Stay within the speed limit and drive safely
- Never use the car to race or to try to impress others
- Never give rides to hitchhikers

I promise that I will make sure I can stay focused on driving.

- Never text while driving (writing, reading or sending messages)
- Never talk on the cell phone — including handsfree devices or speakerphone — while driving
- Drive with both hands on the wheel
- Never eat or drink while driving
- Drive only when I am alert and in emotional control
- Call my parents for a ride home if I am impaired in any way that interferes with my ability to drive safely, or if my driver is impaired in any way
- Never use headphones or earbuds to listen to music while I drive

I promise that I will respect laws about drugs and alcohol.

- Drive only when I am alcohol and drug free
- Never allow any alcohol or illegal drugs in the car
- Be a passenger only with drivers who are alcohol and drug free

I promise that I will be a responsible driver.

- Drive only when I have permission to use the car and I will not let anyone else drive the car unless I have permission
- Drive someone else's car only if I have parental permission
- Pay for all traffic citations or parking tickets
- Complete my family responsibilities and maintain good grades at school as listed here: _____
- Contribute to the costs of gasoline, maintenance, and insurance as listed here: _____

RESTRICTIONS:

I agree to the following restrictions, but understand that these restrictions will be modified by my parents as I get more driving experience and demonstrate that I am a responsible driver.

- For the next _____ months, I will not drive after _____ pm.
- For the next _____ months, I will not transport more than _____ teen passengers (unless I am supervised by a responsible adult).
- For the next _____ months, I won't adjust the stereo, electronic devices, or air conditioning/heater while the car is moving.
- For the next _____ months, I will not drive in bad weather.
- I understand that I am not permitted to drive to off limit locations or on roads and highways as listed here: _____

- Additional restrictions: _____

PENALTIES FOR AGREEMENT VIOLATIONS

- Drove while texting (composed, read or sent message or email with phone).
NO DRIVING FOR _____ MONTHS
- Drove while talking on the cell phone (including handsfree or speakerphone).
NO DRIVING FOR _____ MONTHS
- Drove after drinking alcohol or using drugs.
NO DRIVING FOR _____ MONTHS
- Got ticket for speeding or moving violation.
NO DRIVING FOR _____ MONTHS
- Drove after night driving curfew.
NO DRIVING FOR _____ WEEKS/MONTHS
- Drove too many passengers.
NO DRIVING FOR _____ WEEKS/MONTHS
- Broke promise about seat belts (self and others).
NO DRIVING FOR _____ WEEKS/MONTHS
- Drove on a road or to an area that is off limits.
NO DRIVING FOR _____ WEEKS/MONTHS

I agree to follow all the rules and restrictions in this agreement. I understand that my parents will impose penalties, including removal of my driving privileges, if I violate the agreement. I also understand that my parents will allow me greater driving privileges as I become more experienced and as I demonstrate that I am always a safe and responsible driver.



SIGNATURES

Driver: _____ Date: _____

Parent promise: I also agree to drive safely and to be an excellent role model.

Parent (or guardian): _____ Date: _____

Parent (or guardian): _____ Date: _____