Patient Health Questionnaire (1). PHQ-9. NIMH

Over the last 2 weeks, how often had the following symptoms:

FILL IN THE DOTS

	No Days	Few Days	More Than Half the Days	Most Days
1. Little Interest or pleasure in activities	0	0	0	0
2. Feeling down, depressed, without hope	0	0	0	0
3. Trouble falling, staying, or excessive sleeping	0	0	0	0
4. Feeling tired, reduced or absent energy	0	0	0	0
5. Reduced appetite, or overeating	0	0	0	0
6. Feeling down, that you are a failure, or let your family down	0	0	0	0
7. Trouble concentrating, at work, or at home watching TV, or reading	0	0	0	0
8. Moving or speaking slowly or too much energy, fidgety, restless	0	0	0	0
9. Thoughts about hurting yourself, dying	0	0	0	0

CIRCLE THE YES or NO

10. Recently, have you felt that you or your family would be better off if you were dead	yes	no
11. In the past few weeks, have you thought about killing yourself	yes	no
12. Have you ever tried to kill yourself?	yes	no
13. If yes, how? _____ When? _____		
14. Have you though about killing yourself today?	yes	no

Let the nurse know if you want to discuss this questionnaire with someone. Thank you.

Patient Health Questionnaire (2). Risk Factors for Suicide

Follow-up for Depression/Risk Factors for Suicide

Please CIRCLE the yes or no.

1.	Have you had depression in your past?	yes	no
2.	Have you had a relative who had depression or has committed suicide?	yes	no
3.	Have you had depression since age 65?	yes	no
4.	Have/are you taking medication for depression?	yes	no
5.	Have you been diagnosed with depression by your FNP, family doctor or psychiatrist?	yes	no
6.	Are you receiving counseling from a licensed counselor (LPC, MSW, PhD, Psychiatrist)?	yes	no
7.	Are you involved in any group counseling?	yes	no
8.	If taking, has medications helped reduce your symptoms and improved your mood, energy, sleep, concentration or appetite?	yes	no
9.	Have you stopped your medication due to side effects or lack of improvement?	yes	no
10.	Do you use alcohol-containing drinks regularly?	yes	no
11.	Do you have guns in your home?	yes	no
12.	Do you have trigger locks and locked gun cabinets?	yes	no

Are you aware of the symptoms of depression? These symptoms include:

Reduced interest, pleasure, and ability to concentration - mental changes
Problems with falling asleep, excessive sleeping, tiredness - changes in sleeping
Reduced appetite with weight loss, increased eating - changes in self-regulation
Thoughts of hurting yourself, better off if you were dead - self-destructive symptoms

Let the doctor know if you want to discuss this follow-up questionnaire. Thank you.

Patient Health Questionnaire (3). Columbia-SSRS - Suicide Intent/Plan

Follow-up for Suicidal Thoughts and Actions. A healthcare professional will question you about your thoughts, plans, previous and current actions.

		Past 6 Months	Lifetime
1.	Have you had thoughts of being dead or wishing you could go to sleep and never awaken?	yes/no	yes/no
2.	Have you had occasional thoughts, without a plan on how to commit suicide?	yes/no	yes/no
3.	Have you had many suicidal thoughts but without specific plans to commit suicide?	yes/no	yes/no
4.	Have you had suicidal thoughts and developed plans about how to end your life?	yes/no	yes/no
5.	Do you feel committed to your plan to end your life, and have all the details worked out?	yes/no	yes/no
6.	Have you tried to injure yourself wanting to die?		yes/no
7.	Has your attempt to kill yourself ever been interrupted by a family member or friend?		yes/no
8.	Have you started your plan, but stopped yourself by not completing the suicide plan?		yes/no
9.	Have completed your suicide plan, but survived?		yes/no
10.	What methods were you planning on using to commit suicide?		
	Gun Overdose Car-accident. Hanging/Suffocation Fall _____		
11.	Have you had multiple suicide attempts?		yes/no

Scoring and Remarks from Suicide Risk Reduction

Patient Health Questionnaire (1)

PHQ-9	Not at all	0 points
	Several Days	1 point
	More than Half	2 points
	Every Day	3 points

Scores	0-4	minimal depression	see doctor, may not need meds
	5-9	mild depression	see doctor, may need medications
	10-14	moderate depression	see doctor, counseling, medication
	15-19	moderate depression plus	see doctor, counseling, medication
	20-27	severe depression	see doctor, medication, counseling psychotherapy, hospital evaluation?

NIMH Suicide Risk Screening

Yes or no answers, (4) questions
Each question with increasing intent, planning to commit suicide.
Questions 3 and 4, if yes, need to seek help for patient today.

Patient Health Questionnaire (2)

Designed to help identify the risk factors for suicidal thoughts and intent.

Patient Health Questionnaire (3)

NOTE: A psychiatrist, physician, psychiatric NP pr PA should give the questions, discuss them fully with the patient, and treat to their level of expertise.

C-SSRS Columbia-Suicide Severity Rating Scale. Cognitively Impaired Baseline/Screening

Page 1 is designed to develop through interview, the behaviors related to depression and the level of thought, and intent to commit suicide. Page 2 is designed to do a thorough assessment of the planning, severity, methods, and intent to commit suicide. This should be done by a mental health professional who has been trained to use this form, and has considerable experience with depression, suicide, psychiatric illness.