Patient Self Report

Vital Signs (office use only)

BP: _____/_____ Pulse: _____bpm Weight: _____ lbs.

Patient Name: _____

Date Of Birth: ____/____/____ **Today's Date:** ____/____/____

PHQ-9

Over the past 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**
1. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
2. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
3. Trouble falling asleep, 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** (**please circle which**)	**0**	**1**	**2**	**3**
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading, watching television, doing school work, etc.	**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**
	Column Totals	_____ + _____ + _____		
	Add Totals Together			

10. If you checked off any problems, how difficult have those 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

11. Has there been a time in the past month when you have had serious thoughts about ending your life?

□ No □ Yes (if yes, were there any attempts?)

_____

_____

12. Have you had, or do you currently have any thoughts about harming others?

If yes describe:

_____

_____

Please see other side of form for more questions

Patient Self Report

SINCE LAST VISIT

1. Have you experienced major stress which you feel has caused your mood to change?
If yes describe:

_____

_____

_____

2. Have you experienced other medical problems or changes in medication?
If yes describe:

_____

_____

_____

3. Have you used any illegal drugs? If so indicate type and amount:

_____

4. Indicate your use of the following substances:

Substance	Caffeine	Nicotine	Alcohol	Marijuana
Frequency per day	_____ Cups	_____ Packs	_____ Drinks	_____
Frequency per week	_____ Cups	_____ Packs	_____ Drinks	_____

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**
Total score for each column				
Total Score				

If you have checked off any problems, how difficult 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		Very difficult	
Somewhat difficult		Extremely difficult	