Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT HEALTH QUESTIONNAIRE (PHQ-9 GAD-7)**

**A.** Over the **last 2 weeks**, how often have you been bothered by ANY of the following problems?

 **Not at all Several More Nearly**

 **days than half every**

 **the days 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 asleep 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, 0 1 2 3

 OR feel you have let yourself or your family down

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 7. Trouble concentrating on things, such as reading the 0 1 2 3

 newspaper or watching television

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 8. Moving or speaking so slowly that other people could 0 1 2 3

 have noticed? OR the opposite, being so fidgety or restless

 that you have been moving around a lot more than usual

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 9. Thoughts that you would be better off dead 0 1 2 3

 OR thoughts of hurting yourself in some way

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Score \_\_\_\_ + \_\_\_\_ + \_\_\_\_ + \_\_\_\_ Total Score \_\_\_\_

**Have these problems made it difficult to do your work, take care of things at home, or get along with other people?**

 Not at all difficult Somewhat difficult Very difficult Extremely difficult

=============================================================================================

**B. Over the last 2 weeks how often have you been bothered Not at all Several More Nearly**

 **by ANY of the following problems days than half every**

 **the days day**

 1. Feeling nervous anxiety 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

 Score \_\_\_\_ + \_\_\_\_ + \_\_\_\_ + \_\_\_\_ Total Score \_\_\_\_