Relationship ReDiscovery Center
Depression and Anxiety Screening

These screening tools are helpful in exploring how your life stressors are impacting you.

If you are seeking services as a couple, please make two copies, one for each of you.

When answering the questions think about the last two weeks.

Also please don't forget the last question which many tend to overlook.

Please forward completed forms:

by fax to: 239-324-9743

or

by mail to: Relationship ReDiscovery Center LLC
444 Main St.
Lewiston, ME 04204

As always, if you have any question please do not hesitate to call Bill at 207-689-5412

I look forward to connecting with you.

Thank You,

Bill Gould LCPC

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 figety 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, please refer to accompanying scoring card).		TOTAL:		

10. 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	_____

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NAME _____ DATE _____

GAD-7 anxiety scale

Over the last 2 weeks, how often have you been bothered by the following problems?				
	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 is 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* _____ =	Add Columns	_____ +	_____ +	_____
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?				
Circle one	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

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