

Patient Health Questionnaire (PHQ-9)

Name: _____

Date: _____

Over the last 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. 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 in some way	0	1	2	3

For office coding: Total Score _____ = _____ + _____ + _____

Total Score _____

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

General Anxiety Disorder (GAD-7)

NAME _____

DATE _____

1. 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
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
<i>Add the score for each column</i>				
TOTAL SCORE (add your column scores)				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, 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?	☐ 0	☐ 1	☐ 2	☐ 3

Scoring Add the results for question number one through seven to get a total score.

If you score 10 or above you might want to consider one or more of the following:

1. Discuss your symptoms with your doctor,
2. Contact a local mental health care provider or
3. Contact my office for further assessment and possible treatment.

Although these questions serve as a useful guide, only an appropriate licensed health professional can make the diagnosis of Generalized Anxiety Disorder.

A score of 10 or higher means significant anxiety is present. Score over 15 are severe.

GUIDE FOR INTERPRETING GAD-7 SCORES

Scale	Severity
0-9	None to mild
10-14	Moderate
15-21	Severe

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

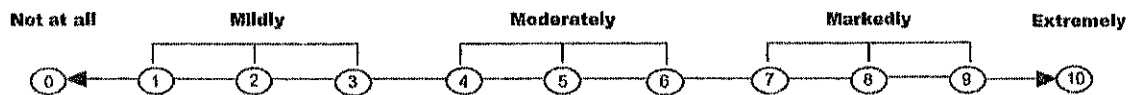
SHEEHAN DISABILITY SCALE

A BRIEF, PATIENT RATED, MEASURE OF DISABILITY AND IMPAIRMENT

Please mark **ONE** circle for each scale.

WORK* / SCHOOL

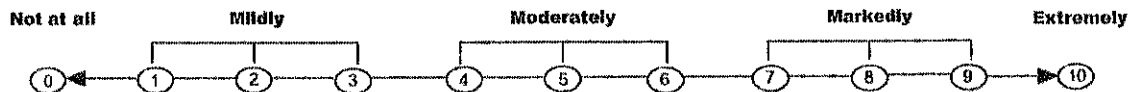
The symptoms have disrupted your work / school work:



☐ I have not worked /studied at all during the past week for reasons unrelated to the disorder.
* Work includes paid, unpaid volunteer work or training

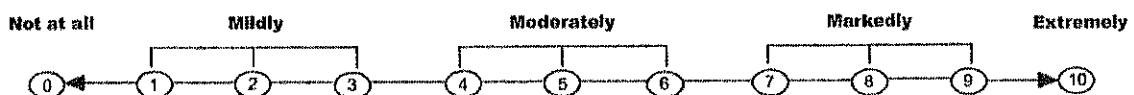
SOCIAL LIFE

The symptoms have disrupted your social life / leisure activities:



FAMILY LIFE / HOME RESPONSIBILITIES

The symptoms have disrupted your family life / home responsibilities:



DAYS LOST

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? _____

DAYS UNDERPRODUCTIVE

On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced? _____

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.

Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? <i>Please check 1 response only.</i>	☐	☐
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? <i>Please check 1 response only.</i>		
☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry*. 2000;157:1873-1875.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name			Today's Date						
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.					Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?									
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?									
3. How often do you have problems remembering appointments or obligations?									
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?									
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?									
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?									
Part A									
7. How often do you make careless mistakes when you have to work on a boring or difficult project?									
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?									
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?									
10. How often do you misplace or have difficulty finding things at home or at work?									
11. How often are you distracted by activity or noise around you?									
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?									
13. How often do you feel restless or fidgety?									
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?									
15. How often do you find yourself talking too much when you are in social situations?									
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?									
17. How often do you have difficulty waiting your turn in situations when turn taking is required?									
18. How often do you interrupt others when they are busy?									
Part B									

PATIENT
NAME

DATE

22.

YALE-BROWN OBSESSIVE COMPULSIVE SCALE (Y-BOCS)*

Questions 1 to 5 are about your obsessive thoughts

Obsessions are unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. They usually involve themes of harm, risk and danger. Common obsessions are excessive fears of contamination; recurring doubts about danger, extreme concern with order, symmetry, or exactness; fear of losing important things.

Please answer each question by circling the appropriate number.

1. TIME OCCUPIED BY OBSESSIVE THOUGHTS

SCORE _____

How much of your time is occupied by obsessive thoughts?

- | | | |
|---|---|--|
| 0 | = | None |
| 1 | = | Less than 1 hr/day or occasional occurrence |
| 2 | = | 1 to 3 hrs/day or frequent |
| 3 | = | Greater than 3 and up to 8 hrs/day or very frequent occurrence |
| 4 | = | Greater than 8 hrs/day or nearly constant occurrence |

2. INTERFERENCE DUE TO OBSESSIVE THOUGHTS

SCORE _____

How much do your obsessive thoughts interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of them?

- | | | |
|---|---|---|
| 0 | = | None |
| 1 | = | Slight interference with social or other activities, but overall performance not impaired |
| 2 | = | Definite interference with social or occupational performance, but still manageable |
| 3 | = | Causes substantial impairment in social or occupational performance |
| 4 | = | Incapacitating |

3. DISTRESS ASSOCIATED WITH OBSESSIVE THOUGHTS

SCORE _____

How much distress do your obsessive thoughts cause you?

- | | | |
|---|---|--------------------------------------|
| 0 | = | None |
| 1 | = | Not too disturbing |
| 2 | = | Disturbing, but still manageable |
| 3 | = | Very disturbing |
| 4 | = | Near constant and disabling distress |

4. RESISTANCE AGAINST OBSESSIONS

SCORE _____

How much of an effort do you make to resist the obsessive thoughts? How often do you try to disregard or turn your attention away from these thoughts as they enter your mind?

- | | | |
|---|---|--|
| 0 | = | Try to resist all the time |
| 1 | = | Try to resist most of the time |
| 2 | = | Make some effort to resist |
| 3 | = | Yield to all obsessions without attempting to control them, but with some reluctance |
| 4 | = | Completely and willingly yield to all obsessions |

5. DEGREE OF CONTROL OVER OBSESSIVE THOUGHTS

SCORE _____

How much control do you have over your obsessive thoughts? How successful are you in stopping or diverting your obsessive thinking? Can you dismiss them?

- | | | |
|---|---|---|
| 0 | = | Complete control |
| 1 | = | Usually able to stop or divert obsessions with some effort and concentration |
| 2 | = | Sometimes able to stop or divert obsessions |
| 3 | = | Rarely successful in stopping or dismissing obsessions, can only divert attention with difficulty |
| 4 | = | Obsessions are completely involuntary, rarely able to even momentarily alter obsessive thinking. |

The next several questions are about your compulsive behaviors.

Compulsions are urges that people have to do something to lessen feelings of anxiety or other discomfort. Often they do repetitive, purposeful, intentional behaviors called rituals. The behavior itself may seem appropriate but it becomes a ritual when done to excess. Washing, checking, repeating, straightening, hoarding and many other behaviors can be rituals. Some rituals are mental. For example, thinking or saying things over and over under your breath.

6. TIME SPENT PERFORMING COMPULSIVE BEHAVIORS

SCORE _____

How much time do you spend performing compulsive behaviors? How much longer than most people does it take to complete routine activities because of your rituals? How frequently do you do rituals?

- | | | |
|---|---|---|
| 0 | = | None |
| 1 | = | Less than 1 hr/day or occasional performance of compulsive behaviors |
| 2 | = | From 1 to 3 hrs/day, or frequent performance of compulsive behaviors |
| 3 | = | More than 3 and up to 8 hrs/day, or very frequent performance of compulsive behaviors |
| 4 | = | More than 8 hrs/day, or near constant performance of compulsive behaviors (too numerous to count) |

7. INTERFERENCE DUE TO COMPULSIVE BEHAVIORS

SCORE _____

How much do your compulsive behaviors interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of the compulsions?

- | | | |
|---|---|---|
| 0 | = | None |
| 1 | = | Slight interference with social or other activities, but overall performance not impaired |
| 2 | = | Definite interference with social or occupational performance, but still manageable |
| 3 | = | Causes substantial impairment in social or occupational performance |
| 4 | = | Incapacitating |

8. DISTRESS ASSOCIATED WITH COMPULSIVE BEHAVIOR

SCORE _____

How would you feel if prevented from performing your compulsion(s)? How anxious would you become?

- | | | |
|---|---|--|
| 0 | = | None |
| 1 | = | Only slightly anxious if compulsions prevented |
| 2 | = | Anxiety would mount but remain manageable if compulsions prevented |
| 3 | = | Prominent and very disturbing increase in anxiety if compulsions interrupted |
| 4 | = | Incapacitating anxiety from any intervention aimed at modifying activity |

9. RESISTANCE AGAINST COMPULSIONS

SCORE _____

How much of an effort do you make to resist the compulsions?

- | | | |
|---|---|--|
| 0 | = | Always try to resist |
| 1 | = | Try to resist most of the time |
| 2 | = | Make some effort to resist |
| 3 | = | Yield to almost all compulsions without attempting to control them, but with some reluctance |
| 4 | = | Completely and willingly yield to all compulsions |

10. DEGREE OF CONTROL OVER COMPULSIVE BEHAVIOR

SCORE _____

How strong is the drive to perform the compulsive behavior? How much control do you have over the compulsions?

- | | | |
|---|---|---|
| 0 | = | Complete control |
| 1 | = | Pressure to perform the behavior but usually able to exercise voluntary control over it |
| 2 | = | Strong pressure to perform behavior, can control it only with difficulty |
| 3 | = | Very strong drive to perform behavior, must be carried to completion, can only delay with difficulty |
| 4 | = | Drive to perform behavior experienced as completely involuntary and overpowering, rarely able to even momentarily delay activity. |

 TOTAL SCORE _____

Rapid Mood Screener (RMS)

Are you among the millions of people who have depressive symptoms? Answer the following questionnaire about your medical history and provide it to your doctor or nurse to assist in an important conversation about your mood.

Please select one response for each question. You can complete the **RMS** in less than 2 minutes.

Patient Name _____ Date _____

YES NO

1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed? ☐ ☐

2. Did you have problems with depression before the age of 18? ☐ ☐

3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper? ☐ ☐

4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head? ☐ ☐

5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic? ☐ ☐

6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual? ☐ ☐
