

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name:

DOB:

Date of Referral:

PHQ9		0	1	2	3
Over the last <u>two weeks</u> how often have you been bothered by the following problems? Place an X in the appropriate box		Not at all	Several Days	More than half the days	Nearly every day
A	Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B	Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C	Trouble falling or staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D	Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E	Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G	Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I	Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>

GAD7		0	1	2	3
Over the last <u>two weeks</u> how often have you been bothered by the following problems?		Not at all	Several Days	Over than half the days	Nearly every day
Feeling nervous, anxious, or on edge		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worrying too much about different things		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble relaxing		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being so restless that it's hard to sit still		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming easily annoyed or irritable		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling afraid as if something awful might happen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Score (add your column scores)					
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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>