Name: _____ Date: _____

# PATIENT HEALTH QUESTIONNAIRE (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability.

| **A. During the last 4 weeks, how much have you been bothered by any of the following problems?** | **Not bothered (0)** | **Bothered a little (1)** | **Bothered a lot (2)** |
|---|---|---|---|
| 1. Stomach Pain | ☐ | ☐ | ☐ |
| 2. Back Pain | ☐ | ☐ | ☐ |
| 3. Pain in your arms, legs or joints (knees, hips, etc.) | ☐ | ☐ | ☐ |
| 4. Feeling tired or having little energy | ☐ | ☐ | ☐ |
| 5. Trouble falling or staying asleep, or sleeping too much | ☐ | ☐ | ☐ |
| 6. Menstrual cramps or other problems with your periods | ☐ | ☐ | ☐ |
| 7. Pain or problems during sexual intercourse | ☐ | ☐ | ☐ |
| 8. Headaches | ☐ | ☐ | ☐ |
| 9. Chest pains | ☐ | ☐ | ☐ |
| 10. Dizziness | ☐ | ☐ | ☐ |
| 11. Fainting spells | ☐ | ☐ | ☐ |
| 12. Feeling your heart pound or race | ☐ | ☐ | ☐ |
| 13. Shortness of breath | ☐ | ☐ | ☐ |
| 14. Constipation, loose bowels, or diarrhea | ☐ | ☐ | ☐ |
| 15. Nausea, gas, or indigestion | ☐ | ☐ | ☐ |

***PHQ-15 Score*** ☐ = _____ + _____

| **B. Over the last 2 weeks, how often have you been bothered by any of the following problems?** | **Not at all (0)** | **Several days (1)** | **More than half the days (2)** | **Nearly every day (3)** |
|---|---|---|---|---|
| 1. Feeling nervous anxiety or on edge | ☐ | ☐ | ☐ | ☐ |
| 2. Not being able to stop or control worrying | ☐ | ☐ | ☐ | ☐ |
| 3. Worrying too much about different things | ☐ | ☐ | ☐ | ☐ |
| 4. Trouble relaxing | ☐ | ☐ | ☐ | ☐ |
| 5. Being so restless than it is hard to sit still | ☐ | ☐ | ☐ | ☐ |
| 6. Becoming easily annoyed or irritable | ☐ | ☐ | ☐ | ☐ |
| 7. Feeling afraid, as if something awful might happen | ☐ | ☐ | ☐ | ☐ |

***GAD-7 Score*** ☐ = _____ + _____ + _____

**Have you had a fall this past year?** **Yes** ☐ **No** ☐

**If yes, how many times?** _____

**If yes, please explain on *blank side of paper.***

| C. Questions about anxiety attacks | *No* | *Yes* |
|---|---|---|
| 1. In the last 4 weeks, have you had an anxiety attack – suddenly feeling fear or panic? | ☐ | ☐ |

*If you checked "NO", go to question D*

| | | |
|---|---|---|
| 2. Has this ever happened before? | ☐ | ☐ |
| 3. Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable? | ☐ | ☐ |
| 4. Do these attacks bother you a lot or are you worried about having another attack? | ☐ | ☐ |
| 5. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding or skipping? | ☐ | ☐ |

| D. Over the last 2 weeks, how often have you been bothered by any of the following problems? | Not at all (0) | Several days (1) | More than half the days (2) | Nearly every day (3) |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| 2. Feeling down, depressed or hopeless | ☐ | ☐ | ☐ | ☐ |
| 3. Trouble falling or staying asleep, or sleeping too much | ☐ | ☐ | ☐ | ☐ |
| 4. Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| 5. Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | ☐ | ☐ | ☐ | ☐ |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless than you have been moving around a lot more than usual | ☐ | ☐ | ☐ | ☐ |
| 9. Thoughts that you would be better off dead or hurting yourself in some way | ☐ | ☐ | ☐ | ☐ |

*PHQ-9 Score* ☐ = _____ + _____ + _____

**E. If you checked off any problems on this questionnaire, 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 |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

| F. In the last 4 weeks, how much have you been bothered by any of the following problems? | Not bothered | Bothered a little | Bothered a lot |
|---|---|---|---|
| 1. Worrying about your health | ☐ | ☐ | ☐ |
| 2. Your weight or how you look | ☐ | ☐ | ☐ |
| 3. Little or no sexual desire or pleasure during sex | ☐ | ☐ | ☐ |
| 4. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend | ☐ | ☐ | ☐ |
| 5. The stress of taking care of children, parents, or other family members | ☐ | ☐ | ☐ |
| 6. Stress at work, outside of the home or at school | ☐ | ☐ | ☐ |
| 7. Financial problems or worries | ☐ | ☐ | ☐ |
| 8. Having no one to turn to when you have a problem | ☐ | ☐ | ☐ |
| 9. Something bad that happened recently | ☐ | ☐ | ☐ |
| 10. Thinking or dreaming about something terrible that happened to you in the past – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act | ☐ | ☐ | ☐ |

| G. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? | *No* | *Yes* |
|---|---|---|
| | ☐ | ☐ |

**H. What is the most stressful thing in your life right now?** _____

_____

| I. Are you taking any medication for anxiety, depression or stress? | *No* | *Yes* |
|---|---|---|
| | ☐ | ☐ |

**J. FOR WOMEN ONLY** | **Questions about menstruation, pregnancy, and childbirth**

1. Which best describes your menstrual periods?

| ☐ Periods are unchanged | ☐ No periods because pregnant or recently gave birth | ☐ Periods have become irregular or changed in frequency, duration, or amount | ☐ No periods for at least a year | ☐ Having periods because taking hormone replacement (estrogen) therapy or oral contraceptives |
|---|---|---|---|---|

| 2. During the week before your period starts, do you have a serious problem with your mood – like depression, anxiety, irritability, anger, or mood swings? | No (or does not apply) | Yes |
|---|---|---|
| | ☐ | ☐ |
| 3. If YES, do these problems go away by the end of your period? | ☐ | ☐ |
| 4. Have you given birth within the last 6 months? | ☐ | ☐ |
| 5. Have you had a miscarriage within the last 6 months? | ☐ | ☐ |
| 6. Are you having difficulty getting pregnant? | ☐ | ☐ |

**Do you smoke tobacco?** **Yes** ☐ **No** ☐

**If yes, when was the last time you smoked? Date:** _____

**If yes, do you want to quit?** **Yes** ☐ **No** ☐

Name: _____ Date: _____

# COLUMBIA-SUICIDE SEVERITY RATING SCALE

***Screen Version – Recent***

| SUICIDE IDEATION DEFINITIONS AND PROMPTS | Past Month | |
|---|---|---|
| Ask questions that are bolded and underlined | YES | NO |
| **Ask questions 1 and 2** | | |
| **1. Wish to be Dead:**<br>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.<br>***Have you wished you were dead or wished you could go to sleep and not wake up?*** | | |
| **2. Suicidal Thoughts:**<br>General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan.<br>***Have you actually had any thoughts of killing yourself?*** | | |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.** | | |
| **3. Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**<br>Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it ... and I would never go through with it."*<br>***Have you been thinking about how you might kill yourself?*** | | |
| **4. Suicidal Intent (without Specific Plan):**<br>Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*"<br>***Have you had these thoughts and had some intention of acting on them?*** | | |
| **5. Suicide Intent (with Specific Plan):**<br>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.<br>***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** | | |
| **6. Suicide Behavior Question:**<br>***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***<br>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.<br>**If YES, ask:** ***How long ago did you do any of these?***<br>• Over a year ago? • Between three months and a year ago? • Within the last three months? | | |

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Name: _____

Date: _____

| The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems. | | | | | | |
|---|---|---|---|---|---|---|
| **Questions:** | 0 | 1 | 2 | 3 | 4 | |
| 1. How often do you have a drink containing alcohol? | Never (skip to 9-10) | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week | |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more | |
| 3. How often do you have six or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 4. How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 8. How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 9. Have you or someone else been injured because of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year | |
| 10. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, during the last year | |
| | | | | | **TOTAL** | |