

Patient Health Questionnaire PHQ-15, PHQ-9, GAD-7

Patient name / case identification number (FID) / barcode:

Time of assessment:

Entry Exit

Assessment date:

___ / ___ /20___

This questionnaire is an important tool to help us give you the best possible treatment. Your answers can help us to better understand your symptoms.

Please answer each question as best you can.

PHQ-15

During the past week, how much have you been bothered by any of the following problems?

(Please tick the answer that suits you best)

	Not bothered at all 0	Bothered a little 1	Bothered a lot 2
1. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pain in your arms, legs, or joints (knees, hips, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Menstrual cramps or other problems with your periods (women only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Feeling tired or having low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHQ-9

Over the last week, how often have you been bothered by any of the following problems?

(Please tick the answer that suits you best)

	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. 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"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. 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"/>

GAD-7

Over the last week, how often have you been bothered by the following problems?

(Please tick the answer that suits you best)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>