Village Internal Medicine Group

Thorough, compassionate care with diagnosticians specialized in adult healthcare

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				
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 that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
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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Lisa E. Medwedeff, M.D. John Wills, M.D. Howard McKay, NP

Name:_____ Date:_____

Generalized Anxiety Disorder 7-item (GAD-7) scale

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
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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Patient Adherence Questionnaire

1. How often have you taken your medication(s) during the last week? Please check the description that best describes your medication use.

   - ☐ a. I have taken my medications every day without missing a day.
   - ☐ b. I have missed taking my medications only one day.
   - ☐ c. I have only missed taking my medications two days.
   - ☐ d. I have missed taking my medications three or four days.
   - ☐ e. I have missed taking my medications five or more days.
   - ☐ f. I have stopped taking my medications.

2. Have you made any changes in how you take your medication(s)? Please check any that apply for the past week.

   - ☐ a. I have reduced my dose at times because I am feeling better.
   - ☐ b. I have reduced my dose at times because of the medication(s) side-effects.
   - ☐ c. I have increased my dose at times because I am feeling worse.
   - ☐ d I have not taken my medication as directed because I cannot afford it.
   - ☐ e. I have always taken my medication as prescribed.

FIBSER

1. Choose the response that best describes the frequency (how often) of the side effects of the medication you have taken within the past week for your depression. Do not rate side effects if you believe they are due to treatments that you are not taking for medical conditions other than depression. Rate the frequency of these side effects for the past week.

No side effects	Present 10% of the time	Present 25% of the time	Present 50% of the time	Present 75% of the time	Present 90% of the time	Present all of the time
☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6

2. Choose the response that best describes the intensity (how severe) of the side effects that you believe are due to the medication you have taken within the last week for your depression. Rate the intensity of the side effect(s), when they occurred, over the last week.

No side effects	Present 10% of the time	Present 25% of the time	Present 50% of the time	Present 75% of the time	Present 90% of the time	Present all of the time
☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6

3. Choose the response that best describes the degree to which antidepressant medication side effects that you have had over the last week have interfered with your day-to-day functions.

No side effects	Present 10% of the time	Present 25% of the time	Present 50% of the time	Present 75% of the time	Present 90% of the time	Present all of the time
☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6