Name_____
Date of Birth_____
MRN_____

Patient Stress Questionnaire*

Over the ***last two weeks*** , how often have you been bothered by any of the following problems?
(please circle your answer & **check the boxes that apply to you**)

	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've been moving around a lot more than usual	0	1	**2**	**3**
9. ☐ Thoughts that you would be better off dead, or ☐ hurting yourself in some way	0	**1**	**2**	**3**

Total

(10)

add columns:

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 is 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**

Total

(8)

add columns:

*adapted from PhQ 9, GAD7, PC-PTSD and AUDIT 1/24/11

Please also complete next page

Provider:_____