DEPRESSION SCREENING (PHQ-2/PHQ-9)

NAME: ____

DOB: _____/_____/________ **DATE:** _____/_____/________

Over the last ***2 WEEKS***, how often have you been bothered by any of the following problems? **(Circle response)**	**Not at all** (0 days)	**Several days** (3-7 days)	**More than half of the days** (8-10 days)	**Nearly every day** (11-14 days)
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
If you selected "0" to #1-2, you are complete and may sign at the bottom of the page. If you selected anything other than "0", please complete the questions below then sign.				
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 or watching TV	0	1	2	3
8. Moving or speaking so slowly or quickly that other people noticed.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
	TOTAL			

In the past year, have you had serious thoughts of suicide? ☐ **YES** ☐**NO** Have you EVER attempted? ☐ **YES** ☐**NO**	**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**

Patent Signature: ____________________________________ **Provider to Initial:** __________

ANXIETY SCREENING (GAD-2/GAD-7)

NAME: ____

DOB: _____/_____/________ **DATE:** _____/_____/________

Over the last ***2 WEEKS***, how often have you been bothered by any of the following problems? **(Circle response)**	**Not at all (0 days)**	**Several days** (1-7 days)	**More than half of the days** (8-10 days)	**Nearly every day** (11-14 days)
1. Feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
2. Not being able to stop or control worrying	**0**	**1**	**2**	**3**
If you selected "0" to #1-2, you are complete and may sign at the bottom of the page. If you selected anything other than "0", please complete the questions below then sign.				
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 columns		**+**	**+**
	TOTAL			

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**

Patent Signature: ____ **Provider to Initial:** __________