Family Health Center

Staff Use Only:
MRN: _____

PATIENT NAME: _____ **DATE:** _____

ADULT SELF-ASSESSMENT FORM

Please complete the form below to assist the therapist in providing the best care for you. The information you provide is **confidential** and **required** by our accrediting agencies. Please fill out as much information as you can before you meet with the therapist.
If you are unsure of anything on the form or have reservations about answering, please discuss it with the therapist during your assessment.

PRESENTING PROBLEM

Who referred you for this evaluation and why? _____

_____

What are your reasons for seeking treatment at this time? (Check all that apply):

- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal Thoughts
- ☐ Anger Problems
- ☐ Relationship Issues
- ☐ Memory Problems
- ☐ Paranoid Thoughts
- ☐ Hallucinations
- ☐ Sexual Problems
- ☐ Wanting Medication
- ☐ Legal Problems
- ☐ Educational Problems
- ☐ Economic Problems
- ☐ Lack of supports
- ☐ Occupational Problems
- ☐ Behavior Problems
- ☐ Drug/Substance Abuse
- ☐ Recent Death/Loss
- ☐ Other: _____

Are you currently experiencing any problem with the following: (Check all that apply)?

- ☐ Loss of Pleasure/Interest
- ☐ Restlessness
- ☐ Excessive Worry
- ☐ Trouble Concentrating
- ☐ Weight Loss or Gain
- ☐ Easily Angered
- ☐ Nightmares or Flashbacks
- ☐ Excessive Guilt
- ☐ Insomnia
- ☐ Irritability
- ☐ Feelings of Worthlessness
- ☐ Paranoid Thoughts
- ☐ Easily Fatigued
- ☐ Muscle Tension
- ☐ Hallucinations
- ☐ Thoughts of Death or Suicide

What are your goals for treatment or services? _____

_____

_____

Do you have a Psychiatric Advance Directive?

☐ NO ☐ YES (If yes, please provide a copy for your medical records.)

SUPPORT SYSTEMS:

Who do you rely on for emotional and/or basic needs? _____

_____

From your support system, who would you like to have involved in your treatment?

_____

Do you have adequate housing? ☐ NO ☐ YES

How long have you lived at your current address? _____

What do you think are your strengths or strong points? _____

_____

What challenges prevent/stop you from reaching the goals you have set for yourself?

_____

MENTAL HEALTH AND SUBSTANCE USE HISTORY

Please indicate if you have ever received treatment for any of the following:

☐ Depression ☐ Behavioral Disorders ☐ Attention Deficit ☐ Sexual Disorders
☐ Anxiety ☐ Bipolar Disorder Disorder ☐ Other: _____
☐ PTSD ☐ Schizophrenia ☐ Family/Marital Issues _____
☐ Alcohol or Drug Abuse ☐ Eating Disorders

MENTAL HEALTH AND SUBSTANCE USE TREATMENT HISTORY (Inpatient and Outpatient):

DATES	FACILITY/PROVIDER	REASON FOR TREATMENT	WAS TREATMENT BENEFICIAL?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were you compliant with treatment? _____

How was your attendance? _____

List all PAST **medications** used for Mental Health and Substance Use problems:

_____

_____

_____

Is there any **family history** of mental illness or substance abuse?

☐ NO ☐ YES **If yes**, please explain: (which family member, what mental illness or substance?)

_____

_____

_____

SUBSTANCE USE HISTORY:

In the past 12 months…

1. Have you used drugs other than those required for medical reasons?	☐Yes ☐No
2. Do you abuse more than one drug/alcohol at a time?	☐Yes ☐No
3. Are you unable to stop abusing drugs/alcohol when you want to?	☐Yes ☐No
4. Have you ever had blackouts or flashbacks because of drug/alcohol use?	☐Yes ☐No
5. Do you ever feel bad or guilty about your drug/alcohol use?	☐Yes ☐No
6. Does those close to you ever complain about your involvement with drugs/alcohol?	☐Yes ☐No
7. Have you neglected your family because of your use of drugs/alcohol?	☐Yes ☐No
8. Have you engaged in illegal activities to obtain drugs/alcohol?	☐Yes ☐No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs/alcohol?	☐Yes ☐No
10. Have you had any medical problems because of your drug/alcohol use (memory loss, hepatitis, seizures, bleeding)?	☐Yes ☐No

Lifetime Substance Use history:

Please mark any substances that you have used and indicate the following:

SUBSTANCE	**AGE YOU 1ST USED**	**AVERAGE AMOUNT OF USE** For example, 12 beers/day, 2 joints a day, pills per day, ¼ oz	**ROUTE** smoke, snort, oral, IV	**DATE OF LAST USE**	**AMOUNT USED PAST 24 HOURS**	**PATTERN OF USE** episodic, binge, weekend, etc.	**METHOD OF ACQUIRING** dealer, store, friend, etc.
Acid/LSD							
Alcohol							
Bath Salts							
Benzos							
Cocaine/Crack							
Meth							
Heroin							
Inhalants							
Marijuana							
Opiates							
Spice/K2							
Tobacco							
Other							

Have you ever injected a substance/illegal drug (IV)? ☐Yes ☐No

If you have, have you ever shared a needle? ☐Yes ☐No

Have you ever experienced the following symptoms associated with alcohol/drug usage? (Check all that apply):

☐ Loss of Control
☐ Concern from Family
☐ Increased tolerance
☐ Past failure to abstain
☐ Frequent usage
☐ Physical problems
☐ Withdrawal symptoms
☐ Seizures
☐ Cravings
☐ Black Outs
☐ Overdose
☐ Loss of Relationships
☐ Loss of Employment
☐ Financial problems
☐ Paranoia
☐ Hallucinations
☐ Sleep Changes
☐ Weight Change
☐ Arrest(s)/legal problems

What is your perception of your substance use? Are you ready to make a change? (Check all that apply)

☐ Willing to attempt recovery process
☐ It's a problem
☐ Willing to consider it a problem
☐ Handle it by myself
☐ Not willing to engage in recovery
☐ Do not view it as a problem
☐ Engaged in recovery

What has been your longest period of sobriety or abstinence? _____

What Substance Use programs have you tried in the past? (Check all that apply)

☐ 12-Step Meeting ☐ Inpatient ☐ Outpatient ☐ MAT (Medication Assisted Treatment)
☐ Detoxification ☐ Self-Help Group ☐ Self-guided Program

Were these programs helpful? ☐Yes ☐No
Why or why not? _____

GAMBLING SCREEN:

Have you experienced any of the following gambling issues? (Check all that apply)

☐ Lost increasing amounts of money
☐ Preoccupation
☐ Loss of control
☐ Unsuccessful attempts to stop
☐ Returned to "Break Even"
☐ Irritability
☐ Lost family or friends
☐ Jeopardized/lost job
☐ Lied about gambling
☐ Restlessness
☐ Committed illegal acts
☐ Adverse consequences
☐ Jeopardized/lost education opportunities
☐ Other: _____

MEDICAL HISTORY

Tobacco/Nicotine History:

☐ Current, Every Day ☐ Current, occasional ☐ Former ☐ Never used tobacco/nicotine
☐ Cigarettes ☐ Vape/E-Cigs ☐ Smokeless Tobacco (Chew)

If you currently use tobacco/nicotine, do you have a desire to quit: ☐Yes ☐No

Primary Physician's Name: _____

If you do not have a primary care physician, do you need assistance with obtaining one? ☐No ☐Yes

Date of last completed history and physical: (month and year)_____

Height: _____ Weight: _____

If you have not had a physical in the last 12 months, will you allow us to make a referral? ☐No ☐Yes

Indicate any medical problems you are currently having:

☐ Anemia	☐ Cancer _____	☐ High Blood Pressure	☐ Stomachaches
☐ Arthritis	☐ COPD	☐ HIV/AIDS	☐ Thyroid Disease
☐ Asthma/Lung	☐ Diabetes	☐ Kidney Disease	☐ Tuberculosis
☐ Bedwetting	☐ Headaches	☐ Liver Disease	☐ Ulcers
☐Blackouts/dizziness	☐ Head injuries	☐ Seizures	☐ Other: _____
☐ Bowel problems	☐ Heart Disease	☐ Sexually Transmitted	
☐ Breathing problems	☐ Hepatitis	Disease	

☐ **No known medical conditions**

Are you currently being treated for these conditions? ☐ NO ☐ YES

If not, will you allow us to make this referral? ☐ NO ☐ YES

Do you have any **DRUG/Medication ALLERGIES**? ☐ NO ☐ YES (if yes, to what and what is the reaction to taking?): _____

_____

_____

LIST ALL OF YOUR CURRENT MEDICATIONS, DOSAGES, AND THEIR PURPOSE (including non-prescription medications):

MEDICATION NAME:	DOSAGE:	PURPOSE:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ALL PAST SIGNIFICANT SURGERIES / ILLNESSES / ACCIDENT AND THE DATES OF TREATMENT:

TYPE OF SURGERY / ILLNESS / ACCIDENT:	**DATES:**	**HOSPITAL / PROVIDER:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have a **dentist**? ☐No ☐Yes If yes, name of Dentist: _____

If you do not have a dentist, do you need our assistance with obtaining one? ☐No ☐Yes

Are you experiencing any dental problems currently? ☐Yes ☐No

Are you up to date on your immunizations? ☐Yes ☐No

GU/GYN (CIS Females only)

☐ Are you currently pregnant? If yes, how many months_____
☐ No menstrual period over 2 months. Is there a possibility of pregnancy? _____
☐ Pain on urination
☐ How many pregnancies? _____ How many deliveries? _____

FUNCTIONAL SCREENING:

Please indicate if you are currently receiving any of the following services:

☐ Rehabilitation Services ☐ Physical Therapy ☐ Home Health Services
☐ Meal Delivery ☐ Senior Services

Do you have any of the following disabilities?

☐ Autism	☐ Emotional disturbance	☐ Muteness
☐ Blindness	☐ Hearing impairment	☐ Orthopedic disability
☐ Deafness	☐ Illiteracy	☐ Seizures
☐ Developmental delay	☐ Learning disability	☐ Speech impairment
☐ Difficulty with walking	☐ Intellectual Disability	☐ Visual impairment

Do you have any adaptive equipment such as glasses, hearing aids, leg braces, etc.?
If yes, what? _____

Please indicate if you are having any current problems in any of the following areas:

PERSONAL SAFETY:
☐ Confusion
☐ Judgment
☐ Reliability
☐ Impulse control
☐ Memory

PERSONAL CARE:
☐ Managing medications
☐ Managing money
☐ Grooming or hygiene
☐ Housekeeping

ACCESS TO SERVICES:
☐ Transportation
☐ Shopping
☐ Ability to keep appointments
☐ Valid License

COMMUNICATION:
☐ Hearing impairment
☐ Sight impairment
☐ Speech impairment

NUTRITIONAL ASSESSMENT:

1. Do you have any **food** allergies? If yes, to what: _____ ☐ NO ☐ YES
2. Experienced a weight gain or loss of 10 pounds or more in the last 3 months? ☐ NO ☐ YES
3. Do you engage in binge eating? ☐ NO ☐ YES
4. Do you ever induce vomiting after eating? ☐ NO ☐ YES
5. Do you have any dental problems that interfere with eating? ☐ NO ☐ YES
6. Has your food intake or appetite decreased in the last month? ☐ NO ☐ YES
7. Do you want a referral to a dietary specialist? ☐ NO ☐ YES

PAIN ASSESSMENT:

1. Using the worst pain you have ever had as a reference, please rate any current pain you are experiencing on a scale of 1 to 10 (0 being the no pain, 10 being the worst pain): RATING (0 to 10) _____
2. If you are currently having trouble with pain, what is the:
   If yes: Location: _____ Frequency: _____ Duration: _____
3. Do you experience any difficulty with **chronic** pain? ☐ NO ☐ YES
   If yes: Location: _____ Frequency: _____ Duration: _____
4. Has pain changed your daily lifestyle in any of the following areas? (Please check as many as apply)
   ☐ Sleep Patterns ☐ Appetite ☐ Relationships ☐ Emotions ☐ Concentration
   ☐ Work/School ☐ Alcohol/drug usage
5. If applicable, are you currently being treated by a healthcare provider for your difficulties with pain? ☐ NO ☐ YES If yes, by whom: _____
6. If not, do you need referred to a pain specialist? ☐ NO ☐ YES

SLEEP ASSESSMENT:

On average, how much sleep do you get each night? _____

Do you have any of the following issues with sleep:

☐ NONE	☐ Mind racing	☐ Frequent urination	☐ Napping during the day
☐ Early wakening	☐ Nightmares	☐ Sleepwalking	
☐ Staying asleep	☐ Night terrors	☐ Parasomnia	☐ Teeth grinding
☐ Middle Insomnia	☐ Frequent wakening		

BIOPSYCHOSOCIAL HISTORY

CHILDHOOD HISTORY:

Where were you born? (City/State) _____

Where did you grow up? (City/State) _____

Who raised you? (Check all that apply)

☐ Biological Parents ☐ Adoptive Parents ☐ Mother ☐Stepmother ☐ Father ☐Stepfather

Other (please explain): _____

Father/Stepfather: ☐ Living ☐ Deceased

How would you describe your relationship with your father? ☐ Good ☐ Fair ☐ Poor

Medical Issues: _____

Mother/Stepmother: ☐ Living ☐ Deceased

How would you describe your relationship with your mother? ☐Good ☐ Fair ☐ Poor

Medical Issues: _____

Parent's relationship: ☐Married ☐Divorced ☐Never married ☐Separated ☐Remarried ☐Co-habitating

Siblings:

Number of: Brothers:_____ Step/half-brothers:_____ Sisters:_____ Step/half-sisters: _____

Birth order: I AM THE… ☐Oldest ☐Middle ☐Youngest

How would you describe your relationship with your siblings? ☐ Good ☐ Fair ☐ Poor

Were you exposed to any type of physical, sexual, or emotional abuse in childhood?

☐ NO ☐ YES If yes, please explain: _____

_____

_____

EDUCATIONAL AND VOCATIONAL HISTORY:

Circle the highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 G.E.D.

College: 1 2 3 4 5 6

Name of High School: _____

Name of College: _____

How was your educational performance? ☐Below average ☐Average ☐Above average

Did you ever receive special educational services during your school years (e.g., learning disabilities)? ☐NO ☐ YES

If yes, please explain: _____

_____

Are you currently employed: ☐ NO ☐ YES Where: _____ for how long? _____

Job concerns: ☐ Problems with absenteeism ☐ Conflicts with supervisors/coworkers

☐ Not satisfied with my job

If not employed, when did you last work? _____ What was your last job? _____

SOCIAL SERVICES:

Please check any of the following services/benefits which you currently receive:

☐ Medicaid ☐ TANF ☐ SNAP ☐ Housing ☐ SSI/SSDI ☐ Vocational Rehabilitation

☐ Other: _____

If you have children in your care, do they have access to adequate healthcare, dental care, and or educational services? ☐NO ☐ YES

RELATIONSHIP HISTORY:

Sexual Orientation:_____ (straight, lesbian, gay, bisexual, transgender)

Are you comfortable with your sexual orientation? ☐NO ☐ YES

Gender Identity at birth: ☐ Female/CIS ☐ Male/CIS

Current Gender Identity: ☐ M = Male / cisgender ☐ F = Female / cisgender ☐ non-binary
☐ E = Transgender (Female to Male) ☐ A = Transgender (Male to Female)

Sexual History: ☐Monogamous/Steady ☐Multiple sexual partners ☐Celibacy ☐ Unprotected sex

Marital status: ☐Single (never married) ☐Married ☐Divorced ☐Separated ☐Widowed

If married, separated, widowed, or divorced: please complete the following:

Marriage	At what age	For how long	Reason for break up	Number of Children
1st				
2nd				
3rd				
4th				

If single (never married), **do you have any children**? ☐ NO ☐ YES: How many? _____

If you have children, how many total children do you have?

_____ Biological _____ Adopted _____ Stepchildren

Who lives in your household? _____

DOMESTIC VIOLENCE ASSESSMENT:

Do you feel safe in your current relationship? ☐ NO ☐ YES

Is anyone in your home being hurt, hit, threatened, frightened, or neglected? ☐ NO ☐ YES

Have you ever been the victim of a rape or sexual assault as an adult? ☐ NO ☐ YES

If yes, please explain _____

_____

Have there been times during your current or past relationship(s) when you have had physical fights? ☐ NO ☐ YES

Do you ever feel like you must do things that make you uncomfortable to get what you need or to stay safe? ☐ NO ☐ YES

MILITARY HISTORY:

Have you ever served in the Military? ☐ NO ☐ YES: For how long? _____

If yes, which branch of the military? ☐ Army ☐ Navy ☐ Marines ☐ Air Force
☐ Coast Guard ☐ Reserves

Combat experience: ☐ NO ☐ YES

Type of discharge: ☐ Honorable ☐ Medical ☐ Dishonorable ☐ Other: _____

LEGAL HISTORY:

Have you **EVER** been arrested or in trouble with the law? ☐ NO ☐ YES

If yes, what were your charges: _____

_____

What was the legal outcome? _____

_____

Do you have any charges pending? ☐ NO ☐ YES

If yes, please explain_____

Are you currently on: ☐Probation ☐Parole ☐ House arrest ☐ In Work release

If yes, please explain what city/county and what conditions:

_____

_____

Do you need a referral to an attorney for pending legal charges? ☐ NO ☐ YES

SPIRITUALITY ASSESSMENT:

Do you consider yourself part of an organized religion? ☐ NO ☐ YES

If yes, which one? ☐ Catholic ☐ Protestant ☐ Jewish ☐ Muslim ☐Christian

☐ Other _____

How important is religion to you? ☐ Very important ☐ Somewhat important

☐ Somewhat unimportant ☐ Not important

What aspects of your spirituality or spiritual practices do you find most helpful to you (e.g., prayer, meditation, Church services, reading the Bible, etc.)?

_____

Are there any specific practices or restrictions your provider should know about with respect to providing care to you (--e.g., dietary restrictions, use of medications, etc.)? ☐ NO ☐ YES

If yes, what are they? _____

INTERESTS AND LEISURE ACTIVITIES:

Please list your primary areas of interest, hobbies, or leisure activities: _____

_____ _____ _____ _____

How often do you engage in leisure activities: ☐Daily ☐Multiple times per week

☐Weekly ☐Monthly

Do you perform any volunteer work in your community?

☐ NO ☐ YES What kind? _____

SUICIDE ASSESSMENT:

Have you had any previous suicidal thoughts or attempts: ☐ NO ☐ YES, when?

_____

_____

Do you have any current thoughts of suicide or self-harm: ☐ NO ☐ YES, how often?

_____

_____

Have you recently hurt yourself? ☐ NO ☐ YES, when and how? _____

_____

Do you have a plan of how you would hurt yourself?

_____

_____

Precipitating factors:

☐ Recent loss of relationship ☐ Financial problems ☐ Unemployment
☐ Legal problems ☐ Current or Pending ☐ Recent family/friend suicide
☐ Chronic medical/pain incarceration

Risk factors:

☐ Mental illness ☐ Substance Abuse ☐ Access to lethal means
☐ Prior suicide attempts ☐ History of physical abuse ☐ History of sexual abuse
☐ History of trauma or loss ☐ Chaotic family history ☐ Victim of bullying
☐ Victim of discrimination related to sexual orientation ☐ Other: _____

***Protective Factors** (that prevent you from harming yourself-ex. Faith, family, etc.):

_____

_____

Has any person close to you attempted or completed suicide: ☐ NO ☐YES, who?

_____

All persons 18 years and older should complete this form.

INFECTIOUS ILLNESS FORM

TUBERCULOSIS (TB)	
Do you have a productive cough that has lasted for 2+ weeks?	Yes No
Are you coughing up blood?	Yes No
Have you had recent weight loss?	Yes No
Have you had a recent loss of appetite?	Yes No
Are you running a fever?	Yes No
Are you having problems with weakness?	Yes No
Are you feeling tired all the time?	Yes No
Have you ever been exposed to someone with TB?	Yes No
When was your **last TB skin test**?	**Date:**
What were the results of that skin test?	POS NEG
Have you ever had a positive TB skin test?	Yes No
HEPATITIS	
Are you running a fever?	Yes No
Do you have a loss of appetite?	Yes No
Are you experiencing muscle pains?	Yes No
Are you experiencing abdominal muscle spasms?	Yes No
Do you have skin rashes?	Yes No
Are you jaundiced?	Yes No
Are you easily fatigued?	Yes No
Do you experience frequent headaches?	Yes No
Is your abdomen tender or painful?	Yes No
Are you experiencing joint pains?	Yes No
Is your urine orange?	Yes No
Are you experiencing problems with nausea/vomiting?	Yes No
When was your **last Hepatitis test**?	**Date:**
Have you ever had a positive Hepatitis test?	Yes No
HIV/AIDS	
Do you have swollen glands?	Yes No
Do you have fever/night sweats?	Yes No
Do you have diarrhea?	Yes No
Do you have white spots on your throat/mouth?	Yes No
Are you having memory problems?	Yes No
Are you having problems with slowed thought processes?	Yes No
Have you experienced sudden, significant weight loss?	Yes No
Do you have a dry cough?	Yes No
Are you experiencing problems with fatigue?	Yes No
Do you have blue/purplish spots on your skin?	Yes No
Do you have difficulty concentrating?	Yes No
Have you experienced personality changes?	Yes No
When was your **last HIV test**?	**Date:**
Have you ever had a positive HIV test?	Yes No
GENERAL QUESTIONS	
Have you **ever** injected illegal drugs?	Yes No
Are you homosexual or bisexual male?	Yes No
Have you participated in prostitution?	Yes No
Have you had sex with partners infected with or at risk for HIV?	Yes No
Have you lived in a large institutional setting?	Yes No
Are you currently homeless?	Yes No
Are you currently living in a shelter?	Yes No
Have you recently been in jail?	Yes No
FEMALES ONLY	
Are you a female of child bearing age?	Yes No
Are you currently pregnant or suspect you may be pregnant?	Yes No
Do you want/need a referral for prenatal care?	Yes No

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often…Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?
   No or Yes

2. Did a parent or other adult in the household often or very often…Push, grab, slap, or throw something at you? Or Ever hit you so hard that you had marks or were injured?
   No or Yes

3. Did an adult of person at least 5 years older than you ever…Touch or fondle you or have you touch their body in a sexual way? Or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No or Yes

4. Did you often or very often feel that…No one in your family loved you or thought you were important or special? Or Your family didn't look out for each other, feel close to each other, or support each other?
   No or Yes

5. Did you often or very often feel that…You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No or Yes

6. Were your parents ever separated or divorced?
   No or Yes

7. Was your mother or step mother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No or Yes

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   No or Yes

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   No or Yes

10. Did a household member go to prison?
    No or Yes

GENERALIZED ANXIETY DISORDER SCREENER (GAD-7)

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than 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 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
	Add columns			
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

When did these symptoms begin? _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last <u>2 weeks</u>, how often have you been bothered by any of the following problems?

	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 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 have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself	0	1	2	3
	Add columns:			
	TOTAL:			

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 _____