Patient's Name: ____

Today's Date: ____

Please review the following checklist. Check the ones that **you are** experiencing:

____ Disrupted eating pattern (too much or not enough)

____ Disrupted sleeping pattern (too much or not enough)

____ Crying

____ Sadness

____ Low energy level

____ Fatigue

____ Low motivation

____ Low self-esteem

____ Poor Concentration

____ Difficulty making decisions

____ Hopelessness

____ Headaches

____ Nausea / Stomachaches

____ Nervousness

____ Fearfulness

____ Mood Swings

____ Anger

____ High energy level

____ Impulsiveness

____ Easily Distracted

____ Racing thoughts

____ Difficulty in school / work

____ Helplessness

____Decreased interest in activities

____ Thoughts of hurting self

____ Thoughts of hurting others

____ Irritability

____ Overwhelmed

____ Frustration

____ Excessive worrying

____ Restlessness

____ Muscle tension

____ Panic attacks

____ Isolation

____ Difficulty following directions

____ Difficulty completing tasks

____ Poor organization

____ Forgetfulness

____ Fidgeting

____ Difficulty remaining seated

____ Impatience

____ Procrastination

____ Talking excessively

____ Interrupting

____ Becoming bored easily

____ Losing items

____ Nightmares

____ Flashbacks

Checklist completed by: ________________________________ Date: ___________

Reviewed by: ____Date:__________

Patient Health Questionnaire (PHQ-9)

Name________________________________ Date of Birth_________________________________

OVER THE LAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	Not at all	Several Days	More than Half	Nearly Every Day
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless?	0	1	2	3
Trouble falling, or staying asleep? Sleeping too much?	0	1	2	3
Feeling tired or having little or no energy?	0	1	2	3
Poor appetite or over-eating?	0	1	2	3
Feeling bad about yourself-or that you are a failure? Feeling that you have let yourself or your family down?	0	1	2	3
Trouble concentrating on things such as the TV or newspaper?	0	1	2	3
Moving or speaking so slowly that others could notice? Or being so fidgety or restless / moving around more than normal?	0	1	2	3
Thoughts you would be better off dead, or of hurting yourself?	0	1	2	3

If you have 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 others?

- ☐ Not Difficult
- ☐ Somewhat difficult
- ☐ Very Difficult
- ☐ Extremely Difficult

Total Score: __________

GAD-7

Over the **last 2 weeks**, how often have you been bothered by the following problems? *(use " ✓ " to indicate your answer)*	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

(***For office coding: Total Score T*** _______ = _______ + _______ + _______)

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