PHQ-9 DEPRESSION SCREENING TOOL

Patient Name: _____

Date: _____ DOB: _____

Over the last 2 weeks, 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 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 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 in some way	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: ◊	

Scoring: Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

NAME: _____ DOB: _____

Alcohol Use Screening (CAGE)

1. Have you ever felt you should cut down on your drinking?
   ▫ Yes ▫ No
2. Have people annoyed you by criticizing your drinking?
   ▫ Yes ▫ No
3. Have you ever felt bad or guilty about your drinking?
   ▫ Yes ▫ No
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
   ▫ Yes ▫ No

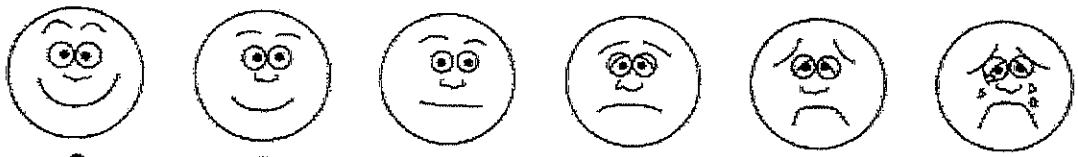
Scoring: Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems.

A total score of 2 or greater is considered clinically significant.

Pain Assessment (FPS)

Please select the face that best describes the pain you are experiencing:

Wong-Baker FACES® Pain Rating Scale



0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

NAME: _____ DOB: _____

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?
   - [ ] Not at all
   - [ ] Slightly
   - [ ] Moderately
   - [ ] Quite a bit
   - [ ] Extremely

2. During the past 4 weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
   - [ ] Not at all
   - [ ] Slightly
   - [ ] Moderately
   - [ ] Quite a bit
   - [ ] Extremely

3. During the past 4 weeks, how much bodily pain have you generally had?
   - [ ] No pain
   - [ ] Very mild pain
   - [ ] Mild pain
   - [ ] Moderate pain
   - [ ] Severe pain

4. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example; if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.
   - [ ] Yes as much as I wanted
   - [ ] Yes, quite a bit
   - [ ] Yes, some
   - [ ] Yes, a little
   - [ ] No, not at all

5. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
   - [ ] Very heavy
   - [ ] Heavy
   - [ ] Moderate
   - [ ] Light
   - [ ] Very light

	YES	NO
6. Can you get places out of walking distance without help? For example; can you travel alone by bus, taxi, or drive your own car?	☐	☐
7. Can you shop for groceries or clothes without help?	☐	☐
8. Can you prepare your own meals?	☐	☐
9. Can you do your own housework without help?	☐	☐
10. Can you handle your own money without help?	☐	☐
11. Do you need help eating, bathing, dressing, or getting around your home?	☐	☐

12. During the past 4 weeks, how would you rate your general health?
   - [ ] Excellent
   - [ ] Very good
   - [ ] Good
   - [ ] Fair
   - [ ] Poor

13. How have things been going for you during the past 4 weeks?
   - [ ] Very well – could hardly be better
   - [ ] Pretty good
   - [ ] Good and bad parts about equal
   - [ ] Pretty bad
   - [ ] Very bad – could hardly be worse

NAME:_____ DOB:_____

14. Are you having difficulties driving your car?
    [ ] Yes, often
    [ ] Sometimes
    [ ] No
    [ ] Not applicable, I do not use a car

15. Do you always fasten your seat belt when you are in a car?
    [ ] Yes, usually
    [ ] Yes, sometimes
    [ ] No

16. How often in the past 4 weeks have you been bothered by any of the following problems?	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up					
Sexual Problems					
Trouble eating well					
Teeth or dentures					
Problems using the telephone					
Tired or fatigue					

17. Have you fallen 2 or more times in the past year?
    [ ] Yes [ ] No

18. Are you afraid of falling?
    [ ] Yes [ ] No

19. Are you a smoker?
    [ ] No
    [ ] Yes, and I might quit
    [ ] Yes, but I'm not ready to quit

20. During the past 4 weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?
    [ ] 10 or more a week
    [ ] 6 – 9 per week
    [ ] 2 – 5 per week
    [ ] 1 drink or less per week
    [ ] No alcohol at all

21. Do you exercise for about 20 minutes 3 or more days a week?
    [ ] Yes, most of the time
    [ ] Yes, some of the time
    [ ] No, I usually do not exercise this much

22. Have you been given any information to help you with the following:
    - Hazards in your house that might hurt you?
      [ ] Yes [ ] No
    - Keeping track of you medications?
      [ ] Yes [ ] No

23. How often do you have trouble taking medicines the way you have been told to take them?
    [ ] I do not have to take medicine
    [ ] I always take them as prescribed
    [ ] Sometimes I take them as prescribed
    [ ] I seldom take them as prescribed

24. How confident are you that you can control and manage most of your health problems?
    [ ] Very confident
    [ ] Somewhat confident
    [ ] Not very confident
    [ ] I do not have any health problems

Reviewed By:_____

NAME: _____ DOB: _____

Current Provider List

Please list the names of all the doctors that you see regularly and yearly

(Use the backside of this page if you need more space to write)

Name of Doctor	Specialty

Current Medication List

Please list all of the medicines you take including over-the-counter drugs and vitamins

(Use the backside of this page if you need more space to write)

Name of Medicine	Dose

Current Medical Equipment Suppliers

Please list the company and the equipment supplied:

Company	Medical Equipment