Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**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 the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over 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'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 the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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ALCOHOL Screening: CAGE Questions

Please Circle "Yes" or "No" for each statement below		
No (0)	Yes (1)	1. Have you ever felt you should cut down on your drinking?
No (0)	Yes (1)	2. Have people annoyed you by criticizing your drinking?
No (0)	Yes (1)	3. Have you ever felt bad or guilty about your drinking?
No (0)	Yes (1)	4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?
Total _____		

Risk For Falling

Please Circle "Yes" or "No" for each statement below			Why it matters
No (0)	Yes (2)	I have fallen in the past year	People who have fallen once are likely to fall again
No (0)	Yes (2)	I use or have been advised to use a cane or Walker to get around safely	People who have been advised to use a cane or Walker may already be more likely to fall
No (0)	Yes (1)	Sometimes I feel unsteady when I am walking	Unsteadiness or needing support while walking are signs of poor balance
No (0)	Yes (1)	I steady myself by holding onto furniture when walking at home	This is also a sign of poor balance
No (0)	Yes (1)	I am worried about falling	People who are worried about falling are more likely to fall
No (0)	Yes (1)	I need to push with my hands to stand up from a chair	This is a sign of weak leg muscles, a major reason for falling
No (0)	Yes (1)	I have some trouble stepping up onto a curb	This is also a sign of weak leg muscles
No (0)	Yes (1)	I often have to rush to the toilet	Rushing to the bathroom, especially at night increases your chance of falling
No (0)	Yes (1)	I have lost some feeling in my feet	Numbness in your feet can cause stumbles and lead to Falls
No (0)	Yes (1)	I take medicine that sometimes makes me feel light-headed or more tired than usual	Side effects from medicines can sometimes increase your chance of falling
No (0)	Yes (1)	I take medicine to help me sleep or improve my mood	These medicines can sometimes increase your chance of falling
No (0)	Yes (1)	I often feel sad or depressed	Symptoms of depression such as not feeling well or feeling slow down are linked to Falls
Total ____		**If you scored >/= 4 points, you may be at risk for falling**	

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

Please Circle "Yes" or "No" for each statement below		
No (0)	Yes (1)	1. Have you ever felt you ought to cut down on your drinking or drug use?
No (0)	Yes (1)	2. Have people annoyed you by criticizing your drinking or drug use?
No (0)	Yes (1)	3. Have you felt bad or guilty about your drinking or drug use?
No (0)	Yes (1)	4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?
Total _____		