## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**DATE** (mm/dd/yyyy)**:** ___________________________

**NAME:** _________________________________________________ **D.O.B.** (mm/dd/yyyy)**:** __________________________

**CELL PHONE** (if 16 yrs. or older)**: ( _______ )** __________________ **PHYSICIAN/PROVIDER:** _________________________

1) Over the last 2 weeks, how often have you been bothered by any of the following problems (circle each)?

| | Not At All | Several Days | More Than Half The Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Feeling down, depressed or hopeless? | 0 | 1 | 2 | 3 |
| 2. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 |
| 3. Trouble falling asleep or staying asleep or sleeping too much? | 0 | 1 | 2 | 3 |
| 4. Poor appetite or overeating? | 0 | 1 | 2 | 3 |
| 5. Feeling tired or having little energy? | 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 or watching TV? | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed or the opposite, being so restless that you have been moving 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 |
| **TOTAL:** | | | | |

2) Over the past year, have you felt depressed or sad most days, even if you felt OK sometimes? ______YES______ NO

3) If you are experiencing any of the problems on this form, 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

4) Has there been a time in the past month where you have had serious thoughts about ending your life? ____ Y____N

5) Have you ever, in your whole life, tried to kill yourself or made a suicide attempt? ____ Y____N

*** If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss with your healthcare clinician, go to a hospital emergency room or call 9-1-1***

## CAGE-AID QUESTIONNAIRE

When thinking about drug use, including illegal drug use and the use of prescription drugs other than as prescribed:

| | YES | NO |
|---|---|---|
| 1. Have you ever felt that you ought to cut down on your drinking or drug use? | | |
| 2. Have people annoyed you by criticizing your drinking or drug use? | | |
| 3. Have you ever felt bad or guilty about your drinking or drug use? | | |
| 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? | | |