Name: _____ Date: _____

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 irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. 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 the symptoms begin? _____

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. 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.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, 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 ☐

Your initials _____ **Date** _____

Please check any of the following feelings, symptoms or situations that apply to you.

__ Depressed
__ Feel inferior
__ Hopelessness
__ Sexual problems
__ Poor concentration
__ Suicidal thoughts
__ Food bingeing
__ Feel detached
__ Guilt
__ Crying spells
__ Poor memory
__ Drug use
__ See no future

__ Headaches
__ Dizziness
__ Fainting spells
__ Racing heart
__ Shortness of breath
__ Choking sensations
__ Feeling anxious
__ Chest pain
__ Nausea
__ Stomach trouble
__ Fatigue
__ Nightmares
__ Muscle tension

__ Irritability
__ Feel panicky
__ Tremors
__ Over-ambitious
__ Shy
__ Lonely
__ Money problems
__ Work stress
__ Legal problems
__ Easily distracted
__ Disorganized
__ Lose items
__ Impatient

__ Break laws
__ Feel empty
__ Hear voices
__ Food purging
__ Emotionless
__ Feel helpless
__ Avoid food
__ Low energy
__ Mood swings
__ Unable to relax
__ Alcohol use

__ Are perfectionistic
__ Tend to be dramatic
__ Unable to enjoy self
__ Bad home conditions
__ Purposely try to hurt others
__ Feel afraid of your emotions

__ Difficulty keeping jobs
__ Make careless mistakes
__ Feel life has no meaning
__ Difficulty remaining still
__ Difficulty making decisions
__ Difficulty finishing projects

__ Tried to harm or kill self
__ See things others do not
__ Difficulty keeping friends
__ Difficulty waiting in lines

__ Lack of interest in doing things
__ Purposely cut or hurt your body
__ Afraid others are out to get you
__ Like to be the center of attention
__ Perceive self as ugly or deformed
__ Try to get away with petty crimes
__ Use other people as a means to get your desires met

__ Difficulty with romantic relations
__ Feel as if people will abandon you
__ Less interested in pleasant activities
__ Always need to be in a relationship
__ Constantly on guard for anything dangerous to happen
__ Constantly need assurance from others

With regard to your sleep, do you...

Yes No Have difficulty falling asleep?
Yes No Have difficulty waking up?
Yes No Frequently wake during the night?
Yes No Sleep really long periods?
Yes No Wake earlier than intended?

In the past month have you...

Yes No Gained weight?
Yes No Lost weight?
Yes No Had poor appetite?
Yes No Noticed an increased appetite?

Do you experience fear of...

Yes No Losing control?
Yes No Going "crazy"?
Yes No Dying?
Yes No Crowded places?
Yes No Social situations?
Yes No Another specific situation, animal, thing?
(please specify _____)

Yes No Do you ever have unwanted repetitive thoughts?
Yes No Do you ever perform unwanted repetitive habits?
Yes No Have periods of time when you feel as if "driven by a motor"?
Yes No Have periods of time when you feel "on top of the world"?
Yes No Have periods of time when you read several books at a time?
Yes No Have periods of time when you feel you can accomplish anything?
Yes No Have periods of time when you go on spending sprees?
Yes No Have periods of time when you drive at high speeds?

Yes No Have you ever witnessed a life threatening event or serious injury?
Yes No Have you ever been in an unusually stressful situation such as a war, disaster, or assault?

If YES to either of the above, did you...

Yes No Experience fear during the event?
Yes No Experience hopelessness or horror during the event?
Yes No Do you now ever experience distressing recollections of the event?
Yes No Do you now ever experience distressing dreams of the event?
Yes No Do you now ever act or feel as if the event was recurring?
Yes No Do you now have difficulty talking about the event?
Yes No Do you now have difficulty seeing anything that reminds you about the event?

I am taking the following Psychotropic medication(s)

_____
_____
_____