

Patient Health Questionnaire

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name _____ Age _____ Sex: Female Male Today's Date _____

1. During the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain in your arms, legs, or joints (knees, hips, etc.)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Menstrual cramps or other problems with your periods.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Pain or problems during sexual intercourse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Fainting spells.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Feeling your heart pound or race.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Constipation, loose bowels, or diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Nausea, gas, or indigestion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. 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
a. Little interest or pleasure in doing things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.
 Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).
 Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

3. Questions about anxiety.

- | | | |
|---|--------------------------------|---------------------------------|
| a. In the <u>last 4 weeks</u> , have you had an anxiety attack — suddenly feeling fear or panic?..... | NO
<input type="checkbox"/> | YES
<input type="checkbox"/> |
|---|--------------------------------|---------------------------------|

If you checked "NO", go to question #5.

- | | | |
|---|--------------------------|--------------------------|
| b. Has this ever happened before?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do some of these attacks come <u>suddenly out of the blue</u> — that is, in situations where you don't expect to be nervous or uncomfortable?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do these attacks bother you a lot or are you worried about having another attack?..... | <input type="checkbox"/> | <input type="checkbox"/> |

4. Think about your last bad anxiety attack.

- | | | |
|---|--------------------------|--------------------------|
| | NO | YES |
| a. Were you short of breath?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Did your heart race, pound, or skip?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Did you have chest pain or pressure?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Did you sweat?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Did you feel as if you were choking?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Did you have hot flashes or chills?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Did you feel dizzy, unsteady, or faint?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Did you have tingling or numbness in parts of your body?... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Did you tremble or shake?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Were you afraid you were dying?..... | <input type="checkbox"/> | <input type="checkbox"/> |

5. Over the last 4 weeks, how often have you been bothered by any of the following problems?

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| | Not at all | Several days | More than half the days |
| a. Feeling nervous, anxious, on edge, or worrying a lot about different things..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you checked "Not at all", go to question #6.

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| b. Feeling restless so that it is hard to sit still..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Getting tired very easily..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Muscle tension, aches, or soreness..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Trouble falling asleep or staying asleep..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Trouble concentrating on things, such as reading a book or watching TV..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Becoming easily annoyed or irritable..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

FOR OFFICE CODING: Pan Syn if all of #3a-d are 'YES' and four or more of #4a-k are 'YES'.
Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

6. Questions about eating.

- | | | |
|--|--------------------------------|---------------------------------|
| a. Do you often feel that you can't control <u>what</u> or <u>how much</u> you eat?..... | NO
<input type="checkbox"/> | YES
<input type="checkbox"/> |
| b. Do you often eat, <u>within any 2-hour period</u> , what most people would regard as an unusually <u>large</u> amount of food?..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you checked 'NO' to either #a or #b, go to question #9.

- | | | |
|---|--------------------------|--------------------------|
| c. Has this been as often, on average, as twice a week for the last 3 months? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

7. In the last 3 months have you often done any of the following in order to avoid gaining weight ?

- | | NO | YES |
|--|--------------------------|--------------------------|
| a. Made yourself vomit? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Took more than twice the recommended dose of laxatives?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Fasted — not eaten anything at all for at least 24 hours?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?... | <input type="checkbox"/> | <input type="checkbox"/> |

8. If you checked 'YES' to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?.....

- | | |
|--------------------------------|---------------------------------|
| NO
<input type="checkbox"/> | YES
<input type="checkbox"/> |
|--------------------------------|---------------------------------|

9. Do you ever drink alcohol (including beer or wine)?.....

- | | |
|--------------------------------|---------------------------------|
| NO
<input type="checkbox"/> | YES
<input type="checkbox"/> |
|--------------------------------|---------------------------------|

If you checked "NO" go to question #11.

10. Have any of the following happened to you more than once in the last 6 months?

- | | NO | YES |
|---|--------------------------|--------------------------|
| a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. You missed or were late for work, school, or other activities because you were drinking or hung over..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. You had a problem getting along with other people while you were drinking..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. You drove a car after having several drinks or after drinking too much..... | <input type="checkbox"/> | <input type="checkbox"/> |

11. If you checked off any problems on this questionnaire, 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
<input type="checkbox"/> | Somewhat
difficult
<input type="checkbox"/> | Very
difficult
<input type="checkbox"/> | Extremely
difficult
<input type="checkbox"/> |
|---|---|---|--|

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank.
Alc Abu if any of #10a-e is 'YES'.

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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Physical Symptoms (PHQ-15)

During the past 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
a. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain in your arms, legs, or joints (knees, hips, etc.) ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Menstrual cramps or other problems with your periods [<i>Women only</i>]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Pain or problems during sexual intercourse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Feeling tired or having low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>