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**

UHS Rev 4/2020

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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The CAGE and CAGE-AID Questionnaires

Patient's Name: ____ Date: ____________________

Physician's Name: ____

The CAGE and CAGE AID Questions

The original CAGE questions appear in plain type. The CAGE questions Adapted to Include Drugs (CAGE-AID) are the original CAGE questions modified by the italicized text.

The CAGE or CAGE-AID should be preceded by these two questions:

1. Do you drink alcohol?
2. Have you ever experimented with drugs?

If the patient has experimented with drugs, ask the CAGE-AID questions. If the patient only drinks alcohol, ask the CAGE questions.

CAGE and CAGE-AID Questions

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?

   Yes No

2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?

   Yes No

3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?

   Yes No

4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

   Yes No

Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.

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Epworth Sleepiness Scale

Support services provided by

Patient's Name ____________________ Today's Date ____________

Age ____________ Gender ____________ Physician's Name ____________________

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you. Place an X in the corresponding space for each situation.

	- 0 - **WOULD NEVER DOZE**	**- 1 -** **SLIGHT CHANCE OF DOZING**	**- 2 -** **MODERATE CHANCE OF DOZING**	**- 3 -** **HIGH CHANCE OF DOZING**
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. a theatre or a meeting)				
A passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				
TOTAL				

SCORING: **0-12 = Normal** | **10-12 = Borderline** | **12-24 = Abnormal**

TOTAL SCORE

____

Nutrition Assessment Form

Please check if you are currently taking any of the following:

☐ Multi-vitamins: brand: ______________________________

☐ Single Vitamins (Vitamin C, E, etc): type(s): ______________________________

☐ Calcium: type: ______________________ Amount: ____________________

☐ Herbs: type(s): ______________________

☐ Other: ____

☐ Food Allergies/ Intolerances: ______________________________________

Please check (ü) everything below that describes your eating pattern and/or lifestyle behaviors:

	1. I eat large portions, get seconds or overfill my plate		11. I don't take time to plan healthy meals ahead
	2. I skip meals or go for longer than 5 hours between meals		12. I am tempted by family/friends to eat unhealthy foods
	3. I dine out (includes carry-out) more than 3 times a week		13. I lack the knowledge to cook healthy
	4. I frequently eat fried foods, fast foods and high fat foods		14. I never feel "full" or satisfied after eating
	5. I frequently eat sweets and desserts (candy, cakes, cookies)		15. When dieting, I go to extremes
	6. I graze (snack on food all day long while doing other things (reading, watching TV, computer work)		16. I drink less than 64 ounces (8 cups) daily (all fluids count)
	7. I eat too quickly		17. I usually drink two or more alcoholic beverages daily
	8. I am an emotional eater (I eat when I am stressed, bored, anxious...)		18. My work schedule hinders my weight loss efforts
	9. I am so busy; I forget to stop and eat		19. I would have a difficult time reducing or giving up: ____________
	10. I am a "picky" eater		Other:

Goals & Readiness Assessment

I want to lose weight because:

My nutrition-related goals are:

If I could change 3 things about my health & nutritional habits, they would be:

The biggest challenge(s) to reaching my nutrition/weight loss goals are: