



## TRIPLER ADOLESCENT AND YOUNG ADULT HEALTH CLINIC

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### The Patient Health Questionnaire (PHQ-9 Mod)

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired or having little energy?				
6. Feeling bad about yourself --- or feeling that you are a failure or that you have let yourself or your family down?				
7. Trouble concentrating on things like school, work, reading, or watching TV?				
8. Moving or speaking slowly that other people could have noticed? Or the opposite --- being so fidgety or restless that You were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the **past year** have you felt depressed, or sad most days even if you felt okay sometimes? ☐ Yes ☐ No

11. 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

12. Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

13. Have you **ever**, in your **whole life**, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

FOR OFFICE USE ONLY Score \_\_\_\_\_

Source: Patient Health Questionnaire Modified for Teens (PHQ-9) (Author: Drs Robert L Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

PC/PHQ-9 Mod/6.4.10/1000

Q. 12 and Q. 13 = Y or TS =  $\geq 11$

## 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

(Use "✓" to indicate your answer)

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 irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score  $T$  \_\_\_\_\_ = \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ )

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

## OPTIONAL QUESTIONS

A) What sex were you assigned at birth?  
(Circle all that apply):

- Male
- Female
- Decline to answer

B) What is your current gender identity?  
(Circle all that apply):

- Male
- Female
- TransMale/Transman
- TransFemale/Transwoman
- Genderqueer
- Another gender (Please Specify): \_\_\_\_\_