PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

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**
☐	☐	☐	☐

Intake Questionnaire For New Adult Patients

This brief questionnaire will help me get to know you better in order to provide the best possible care for you. Please answer as honestly and completely as possible.

Date: _____ **Age:** _____

Name: _____ **DOB:** _____

Please describe the current problems as you see them:

_____

_____

_____

_____

How long has this been going on? _____

_____

_____

What made you decide to come in at this time? _____

_____

_____

What do you hope to gain from this evaluation/session? _____

_____

_____

In the past, how have you coped with difficulties? Were these coping methods helpful?

_____

_____

Intake Questionnaire For New Patients (Child)

This brief questionnaire will help me get to know you better in order to provide the best possible care for you. Please answer as honestly and completely as possible.

Date: _____ **Age:** _____

Name: _____ **DOB:** _____

Please describe the current problems as you see them:

_____

_____

_____

_____

How long has this been going on? _____

_____

_____

What made you decide to come in at this time? _____

_____

_____

What do you hope to gain from this evaluation/session? _____

_____

_____

In the past, how have you coped with difficulties? Were these coping methods helpful?

_____

_____

SYMPTOMS

Check any symptoms or experiences that you have had **in the last month**

Average hours of sleep per night: ____

☐ Difficulty staying asleep

☐ Difficulty falling asleep

☐ Not feeling rested in the morning

☐ Difficulty getting out of bed

☐ Loss of interest in previously enjoyed activities (on most days)

☐ Withdrawing from others

☐ Spending increased time alone

☐ Depressed/down/sad mood

☐ Feeling numb

☐ Rapid mood changes

☐ Irritability

☐ Anxiety/excessive worries

☐ Panic attacks

☐ Feelings of guilt or worthlessness

☐ Avoiding people, activities, or places

☐ Difficulty leaving home

☐ Anger outbursts

☐ Fear of certain objects or situations (heights, animals, flying) If so, describe: _____

☐ Repetitive behaviors or mental acts (counting, checking doors, washing hands)

☐ Easy tearfulness

☐ Feeling hopeless

☐ Fear

☐ Feeling helpless

☐ Feeling like a different person

☐ Difficulty controlling worries

☐ Changes in appetite

If so: Eating more? ☐ Eating less? ☐

☐ Voluntary vomiting

☐ Use of laxatives

☐ Excessive exercise to avoid weight gain

☐ Binge eating

☐ Are you trying to lose weight? _____

☐ Weight gain: _____ lbs

☐ Weight loss: _____ lbs

☐ Difficulty catching your breath

☐ Increased muscle tension

☐ Unusual sweating

☐ Easily startled, jumpy or on edge

☐ Increased energy

☐ Decreased energy

☐ Tremor

☐ Dizziness

☐ Racing thoughts

☐ Intrusive, unwanted memories

☐ Difficulty concentrating or thinking ☐ Memory problems

☐ Flashbacks ☐ Nightmares

☐ Thoughts of harming or killing yourself ☐ Thoughts of harming or killing someone else

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☐ Feeling as if you were outside your body, observing what you are doing, in a detached state

☐ Unable to tell what is real or not real

☐ Persistent, repetitive, intrusive thoughts, impulses, or images

☐ Hearing voices when no one else is present

☐ Unusual visual experiences such as flashes of light or shadows

☐ Feeling that your thoughts are being controlled or planted in your mind

☐ Feeling that others can read your thoughts

☐ Feeling that the television or the radio is communication with you

☐ Feeling that other people are trying to harm you

☐ Difficulty problem solving ☐ Difficulty meeting others' expectations

☐ Difficulty making decisions ☐ Dependency on others

☐ Manipulation of others to fulfill desires ☐ Inappropriate expressions of anger

☐ Self-mutilation/cutting ☐ Difficulty saying "no" to others

☐ Ineffective communication ☐ Feeling a lack of control

☐ Diminished ability to manage stress ☐ Abusive relationship(s)

☐ Difficulty expressing yourself ☐ Concerns about sexuality

Have you seen a counselor, psychologist, psychiatrist, or other mental health professional before?

☐ No ☐ Yes If so:

Name of therapist: _____ Dates of treatment: _____

Reason for seeking help: _____

Name of therapist: _____ Dates of treatment: _____

Reason for seeking help: _____

Name of therapist: _____ Dates of treatment: _____

Reason for seeking help: _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ☐ No ☐ Yes If Yes, please list:

Medication	**Dose**	**How long have you been taking?**	**Is it helpful?**

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? ☐ No ☐ Yes If Yes, please list:

Medication	**Dose**	**How long have you been taking?**

Have you been prescribed **PSYCHIATRIC** medication in the past that you no longer take?

☐ No ☐ Yes If yes, please list:

Medication	**Dose**	**First/last time taking**	**Effect(s) of medication**

Have you been hospitalized for psychiatric reasons? ☐ No ☐ Yes If Yes, describe:

Hospital	**Dates**	**Reason**

Have you ever attempted suicide? ☐ No ☐ Yes If yes, describe:

_____

_____

_____

MEDICAL HISTORY

Please list any medication allergies: _____

Are you **CURRENTLY** under treatment for any medical condition? ☐ No ☐ Yes If Yes, describe:

_____

_____

_____

List any prior illnesses, surgeries, accidents: _____

_____

_____

FAMILY HISTORY

Please check the appropriate box if these conditions are or have been present in your relatives:

	Children	Brother(s)	Sister(s)	Father	Mother	Uncle/Aunt	Grandparents
Anxiety							
Depression							
Bipolar disorder							
ADD/ADHD							
Counseling							
Psychiatric medications							
Psychiatric hospitalization							
Suicide attempt							
Death by suicide							
Drinking or drug problem							

Social History

How was your childhood? _____

Are you currently in a long-term relationship? _____

Have you ever been abused? _____

☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe: _____

_____

_____

_____

_____

Education

Highest grade level completed: _____

Degree-obtained, if applicable: _____

Did you have any disciplinary problems in school? _____

If yes, please explain: _____

Were you considered hyperactive/ADHD in school? _____

If yes, were/are you on any medication? _____

If so, which medication? _____

What kind of grades did you get in school? _____

Have you served in the military? _____ If yes, please describe briefly: _____

What type of discharge/separation? _____

Employment

Are you currently employed? _____ ☐ FT ☐ PT

Employer's name: _____

What type of work do you do? _____

Legal

Have you ever been arrested? _____ If yes, please describe circumstances: _____

Do you have a religious affiliation? _____ If yes, what is it? _____

What kinds of social activities and hobbies do you participate in? _____

Who do you turn to for help with problems? _____

Substance Use

Caffeine: Do you consumer caffeine? _____ If so, in what form (i.e. coffee, energy drink): _____

How many caffeinated beverages per day? _____

Alcohol

Do you drink alcohol? _____ If yes, age at first use: _____

How many drinks do you have per week? _____ Per day/per occasion: _____

Have you ever passed out from drinking? _____ How often? _____

Have you ever "blacked out"? _____ How often? _____

Have you ever had the "shakes"? _____ How often? _____

Have you ever felt you should cut down on your drinking/drug use? _____

Have people annoyed you by criticizing your drinking/drug use? _____

Have you ever felt guilty about your drinking/drug use? _____

Have you ever drunk/used drugs in the morning to steady your nerves or relieve a hangover? _____

Do you use tobacco? ____ If yes, what kind and how often? _____

Other substances:

Drug	**Ever Used?**	**Age 1st use**	**Time since last use**	**Approx use in last 30 days**
Marijuana				
Cocaine				
Crack				
Opioids				
Methamphetamine				
Ecstacy				
Other				

Is there anything else that you would like me to know about you?