PATIENT HEALTH QUESTIONNAIRE FOR ADOLESCENTS (PHQ-A VERSION 3.6.05)

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INSTRUCTIONS: This questionnaire will help in understanding some problems that you may have. Please make sure to circle YES or NO for each question unless the instructions tell you to skip over some questions.

First, here are some questions about depression and your mood.

Have you had any of the following problems during the last 2 weeks?

1. Little interest or pleasure in doing things?	**YES:** Nearly every day in the past 2 weeks.	**YES:** A few days in the past 2 weeks.	**NO**
2. Feeling down, depressed, irritable or hopeless?	**YES:** Nearly every day in the past 2 weeks.	**YES:** A few days in the past 2 weeks.	**NO**
3. Trouble falling asleep, staying asleep, or sleeping too much?	**YES:** Nearly every day in the past 2 weeks.	**YES:** A few days in the past 2 weeks.	**NO**
4. Feeling tired or having little energy?	**YES:** Nearly every day in the past 2 weeks.	**YES:** A few days in the past 2 weeks.	**NO**
5. Poor appetite, weight loss, or overeating?	**YES:** Nearly every day in the past 2 weeks.	**YES:** A few days in the past 2 weeks.	**NO**
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	**YES:** Nearly every day in the past 2 weeks.	**YES:** A few days in the past 2 weeks.	**NO**
7. Trouble concentrating on things like school work, reading, or watching TV?	**YES:** Nearly every day in the past 2 weeks.	**YES:** A few days in the past 2 weeks.	**NO**
8. Moving or speaking so 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?	**YES:** Nearly every day in the past 2 weeks.	**YES:** A few days in the past 2 weeks.	**NO**

9. Have you felt sad, upset, irritable, or depressed on more than half of the days in the past year?	**YES**	**NO**
10. In the past year, have you felt so sad, upset, irritable, or depressed that it has often been hard for you to do your work, take care of things at home, or get along with other people?	**YES**	**NO**
11. In the past year, has there been a time when you didn't feel sad, upset, irritable, or depressed for two months in a row or longer? That is, has there been a time in the past year when you felt happy most of the time for at least two months in a row?	**YES**	**NO**
12. In the last 2 weeks, have you often felt hopeless about the future?	**YES**	**NO**
13. In the last 2 weeks, have you often had thoughts that you would be better off dead, or of hurting yourself in some way?	**YES**	**NO**
14. Has there been a time in the past month when you have had serious thoughts about ending your life?	**YES**	**NO**

15. In the past 2 weeks, have you been so sad, down, irritable, or depressed that it has been difficult for you to do your work, take care of things at home, or get along with other people?
Please circle one of the following answers:

Not difficult at all	A little difficult	Quite difficult	Very difficult	Extremely difficult

Now, here are some questions about fear and anxiety.

16. In the last month, have you had an anxiety attack,when you suddenly felt fear or panic?	**YES**	**NO**

If your answer to the above question was YES, please answer the rest of the questions on this page. If your answer was NO, please turn to the next page.

17. Have you had any other anxiety attacks like this in the past year?	**YES**	**NO**
18. Do these feelings of panic sometimes come suddenly out of the blue - that is, in situations where you don't expect to be nervous or uncomfortable?	**YES**	**NO**
19. Do you often worry about having these anxiety attacks? Or, have you had to change your behavior or your lifestyle to avoid having more attacks?	**YES**	**NO**

Think about your last panic or anxiety attack:		
20. Were you short of breath?	YES	NO
21. Did your heart race, pound, or skip?	YES	NO
22. Did you have chest pain or pressure?	YES	NO
23. Did you sweat?	YES	NO
24. Did you feel as if you were choking?	YES	NO
25. Did you have hot flashes or chills?	YES	NO
26. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	YES	NO
27. Did you feel dizzy, unsteady, or faint?	YES	NO
28. Did you have tingling or numbness in parts of your body?	YES	NO
29. Did you tremble or shake?	YES	NO
30. Were you afraid that you were going crazy or losing control?	YES	NO
31. Were you afraid that you were dying?	YES	NO

32. Have you felt nervous, anxious, or on edge, or have you worried a lot on more than half the days in the last six months?	YES	NO
33. Have you been worrying a lot about many different kinds of things in the last six months?	YES	NO
34. Do you often find that it's very difficult to stop worrying?	YES	NO

In the last six months, have you often been bothered by any of these problems?			
35. Feeling restless so that it is hard to sit still?	**YES: More than half the days in the past 6 months.**	**YES: Less than half the days in the past 6 months.**	**NO**
36. Getting tired very easily?	**YES: More than half the days in the past 6 months.**	**YES: Less than half the days in the past 6 months.**	**NO**
37. Muscle tension, aches, or soreness?	**YES: More than half the days in the past 6 months.**	**YES: Less than half the days in the past 6 months.**	**NO**
38. Trouble falling asleep or staying asleep?	**YES: More than half the days in the past 6 months.**	**YES: Less than half the days in the past 6 months.**	**NO**
39. Trouble concentrating on things such as school work, reading, or watching TV?	**YES: More than half the days in the past 6 months.**	**YES: Less than half the days in the past 6 months.**	**NO**
40. Becoming easily annoyed or irritable?	**YES: More than half the days in the past 6 months.**	**YES: Less than half the days in the past 6 months.**	**NO**

41. How much have problems with fear or anxiety made it difficult for you to do your work, take care of things at home, or get along with other people? **Please circle one of the following answers.**

Not difficult at all	**A little difficult**	**Quite difficult**	**Very difficult**	**Extremely difficult**

Now, here are some questions about alcohol and cigarettes.

Have any of the following things happened to you in the last 6 months?

42. Have there been any days in the past six months when you had five or more drinks of beer, wine or liquor?	**YES: a few days**	**YES: 1 or 2 days**	**NO**
43. Have there been any days in the past six months when you drank so much beer, wine or liquor that you got drunk or more than a little tipsy?	**YES: a few days**	**YES: 1 or 2 days**	**NO**

44. Have you been drinking alcohol, drunk or tipsy from alcohol, or hung over while you were working, studying, going to school, or taking care of other responsibilities?	**YES (more than once)**	**YES (once)**	**NO**
45. Have you missed or been late for school, work, or other responsibilities because you were drinking or hung over?	**YES (more than once)**	**YES (once)**	**NO**
46. Have you driven a car when you were drunk or tipsy from alcohol, or after having several drinks?	**YES (more than once)**	**YES (once)**	**NO**
47. Have you had any problems getting along with other people while you were drinking or because of your alcohol use?	**YES (more than once)**	**YES (once)**	**NO**

48. In the past 6 months, has anyone complained about your alcohol use, or told you that you have a drinking problem?	**YES**	**NO**
49. Has a doctor ever said that you should stop drinking for health reasons?	**YES**	**NO**
50. Have you had any legal problems because of your alcohol use?	**YES**	**NO**
51. Do you feel guilty or upset about your use of alcohol, or do you think that you drink too much, or that you might have an alcohol problem?	**YES**	**NO**

52. How many cigarettes would you say that you have smoked on an average day in the past month?
Please circle one of the following answers.

None	1 or 2 cigarettes	3 cigarettes or more	Half a pack a day (10 cigarettes) or more	A pack a day (20 cigarettes) or more

Now, here are some questions about drug use.

53. Have you used marijuana ("grass," "pot," "weed," or "hash") in the past 6 months?	YES	NO
54. Have you used cocaine or "crack" in the past 6 months?	YES	NO
55. Have you used "ecstasy," mushrooms, LSD, "acid," or other hallucinogenic drugs in the past 6 months?	YES	NO
56. In the past 6 months, have you used any other drugs to get high, including stimulants ("speed"), tranquilizers, or pain killers such as codeine or heroin?	YES	NO
57. In the past 6 months, have you sniffed glue or inhaled sprays or paints to get high?	YES	NO

58. How often have you used these or other kinds of drugs to get high in the past 6 months?
Please circle one of the following answers.

Never	Once	Twice	A few times	More than a few times

Have any of the following things happened to you in the last 6 months?

59. Have you used drugs, or were you high or hung over from drug use while you were going to school, working, studying, or taking care of other responsibilities?	YES (more than once)	YES (once)	NO
60. Have you missed or were late for school, work, or other responsibilities because you were using drugs?	YES (more than once)	YES (once)	NO
61. Have you driven a car when you were "high" from drug use?	YES (more than once)	YES (once)	NO

62. Have you had any problems getting along with other people while you were using drugs or because of your drug use?	**YES (more than once)**	**YES (once)**	**NO**

63. In the past 6 months, has anyone complained about your drug use, or told you that you have a drug problem?	**YES**	**NO**
64. Has a doctor ever said that you should stop using drugs for health reasons?	**YES**	**NO**
65. Have you had any legal problems because of your drug use?	**YES**	**NO**
66. Do you feel guilty or upset about your drug use, or do you think that you use drugs too often, or that you might have a drug problem?	**YES**	**NO**

Now, here are some questions about eating and weight.
67. How much do you weigh? _____ (pounds)
68. How tall are you? _____ (feet) _____ (inches)

69. Do you think that you are too heavy, and that you should try to lose weight?	**YES**	**NO**
70. Do you often worry a great deal about gaining weight or becoming fat?	**YES**	**NO**
71. Does your weight or body shape very strongly affect the way you feel about yourself?	**YES**	**NO**
72. Do you often feel that you can't control what or how much you eat?	**YES**	**NO**
73. Do you sometimes eat what most people would regard as an unusually large amount of food within a 2-hour period?	**YES**	**NO**
74. Have you eaten very large amounts of food like this at least as twice a week, in an average week, for the past 6 months?	**YES**	**NO**

In the past 3 months, have you done any of these things to lose weight or to avoid gaining weight?		
75. Have you exercised almost every day for over an hour to lose or avoid gaining weight?	YES	NO
76. Have you used diet drugs almost every day for months to lose or avoid gaining weight?	YES	NO
77. Have you fasted (not eaten anything) for at least 24 hours to lose or avoid gaining weight?	YES	NO
78. Have you used high doses of laxatives or diuretics to lose or avoid gaining weight?	YES	NO
79. Have you made yourself vomit to lose weight or to avoid gaining weight?	YES	NO
80. Have you used enemas to lose weight or to avoid gaining weight?	YES	NO

81. How often have you done things like this to avoid gaining weight in the last 3 months?
Please circle one of the following answers.

Never	Once or Twice	Less Than Once a Week	At Least Once a Week	At Least Twice a Week

82. **(females only)** Have you had any menstrual periods in the past 3 months?	YES	NO

83. How much have any problems that you may have had with your eating habits or your weight made it difficult for you to do your work, take care of things at home, or get along with other people?
Please circle one of the following answers.

Not difficult at all	A little difficult	Quite difficult	Very difficult	Extremely difficult

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