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SCREENING &KZD

PATIENT HEALTH QUESTIONNAIRE – 9 (PHQ-9)

D Z/ E E / E E& Ed, >d, E/d/ d/s
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ID Number: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? <i>(Use "✓" to indicate your answer)</i>	Not at all (0)	Several Days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Feeling down, depressed, or hopeless	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Feeling tired or having little energy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Poor appetite or overeating	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>	
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.				

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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HITS Tool for Intimate Partner Violence Screening

Please read each of the following activities and fill in circle that best indicates the frequency with which you partner acts in the way depicted.

How often does your partner?	Never (1)	Rarely (2)	Sometimes (3)	Fairly often (4)	Frequently (5)
1. Physically hurt you	<input type="checkbox"/>				
2. Insult or talk down to you	<input type="checkbox"/>				
3. Threaten you with harm	<input type="checkbox"/>				
4. Scream or cuss at you	<input type="checkbox"/>				
Total Score: _____					

Each item is scored from 1-5. Thus, scores for this inventory range from 4-20. A score of greater than 10 is considered positive. Follow AIHI protocol for a positive screen.

AUDIT-C

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?					SCORE
Never (0) <input type="checkbox"/>	Monthly or less (1) <input type="checkbox"/>	Two to four times a month (2) <input type="checkbox"/>	Two to three times per week (3) <input type="checkbox"/>	Four or more times a week (4) <input type="checkbox"/>	
2. How many drinks containing alcohol do you have on a typical day when you are drinking					
1 or 2 (0) <input type="checkbox"/>	3 or 4 (1) <input type="checkbox"/>	5 or 6 (2) <input type="checkbox"/>	7 to 9 (3) <input type="checkbox"/>	10 or more (4) <input type="checkbox"/>	
3. How often do you have six or more drinks on one occasion?					
Never (0) <input type="checkbox"/>	Less than Monthly (1) <input type="checkbox"/>	Monthly (2) <input type="checkbox"/>	Two to three times per week (3) <input type="checkbox"/>	Four or more times a week (4) <input type="checkbox"/>	
Total Score _____					
Add the number for each question to get your total score.					

The AUDIT-C is a 3 question screen that can help identify patients with alcohol misuse. The AUDIT-C is scored on a scale of 0-12 points (scores of 0 reflect no alcohol use in the past year). In men, a score of 4 points or more is considered positive for alcohol misuse; in women, a score of 3 points or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety. The VA's performance measure requires [brief counseling](#) for alcohol use for any patient who scores 5 points or more on the AUDIT-C.