

# PATIENT HEALTH QUESTIONNAIRE (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability

**A. During the last 4 weeks, how much have you been bothered by any of the following problems?**

	Not bothered <b>(0)</b>	Bothered a little <b>(1)</b>	Bothered a lot <b>(2)</b>
1. Stomach pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pain in your arms, legs, or joints (knees, hips, etc.)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Trouble falling or staying asleep, or sleeping too much .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Menstrual cramps or other problems with your periods.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Pain or problems during sexual intercourse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Fainting spells.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Feeling your heart pound or race.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Constipation, loose bowels, or diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Nausea, gas, or indigestion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHQ-15 Score  =  +

**B. Over the last 2 weeks, how often have you been bothered by any of the following problems?**

	Not at all <b>(0)</b>	Several days <b>(1)</b>	More than half the days <b>(2)</b>	Nearly every day <b>(3)</b>
1. Feeling nervous anxiety or on edge .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless that it is hard to sit still.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GAD-7 Score  =  +  +