Name_____ Date_____

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 SCORING***** *0* + _____ + _____ + _____

=Total Score: _____

Level of depression/Provider initials

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**
☐	☐	☐	☐

Name_____ Date_____

GAD-7 Anxiety

Over the **last two weeks**, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
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 ☐

Column totals 0 ____ + ____ + ____ + ____ =

Total score _____

Level of anxiety/Provider initials

If you checked **any** problems, how **difficult** have they 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
☐	☐	☐	☐

Adverse Childhood Experience (ACE) Questionnaire

Name: _____ Date: _____

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household <u>often</u>:

   Swear at you, insult you, put you down, or humiliate you?

   Or

   Act in a way that made you afraid that you might be physically hurt?

   ☐ Yes ☐ No If Yes, enter 1 _____

2. Did a parent or other adult in the household <u>often</u>:

   Push, grab, slap, or throw something at you?

   Or

   Ever hit you so hard that you had marks or were injured?

   ☐ Yes ☐ No If Yes, enter 1 _____

3. Did an adult or person at least 5 years older than you <u>ever</u>:

   Touch or fondle you or have you touch their body in a sexual way?

   Or

   Attempt or actually have oral, anal, or vaginal intercourse with you?

   ☐ Yes ☐ No If Yes, enter 1 _____

4. Did you <u>often</u> feel that:

   No one in your family loved you or thought you were important or special?

   Or

Adverse Childhood Experience (ACE) Questionnaire

Your family didn't look out for each other, feel close to each other, or support each other?

☐ Yes ☐ No If Yes, enter 1 _____

5. Did you <u>often</u> feel that:

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   Or

   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   ☐ Yes ☐ No If Yes, enter 1 _____

6. Were your parents <u>ever</u> separated or divorced?

   ☐ Yes ☐ No If Yes, enter 1 _____

7. Were any of your parents or other adult caregivers:

   <u>Often</u> pushed, grabbed, slapped, or had something thrown at them?

   Or

   <u>Sometimes or often</u> kicked, bitten, hit with a fist, or hit with something hard?

   Or

   <u>Ever</u> repeatedly hit over at least a few minutes or threatened with a gun or knife?

   ☐ Yes ☐ No If Yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   ☐ Yes ☐ No If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   ☐ Yes ☐ No If Yes, enter 1 _____

10. Did a household member go to prison?

    ☐ Yes ☐ No If Yes, enter 1 _____

ACE SCORE (Total "Yes" Answers): _____

Risk level / Provider initials