# From the Heart Counseling Services

## Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date: _____ Patient Name: _____ Date of Birth: _____

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

| PHQ-9 | 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 |

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

**Not difficult at all** **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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

| GAD-7 | 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's 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 |

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

**Not difficult at all** **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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