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
Add the score for each column				

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 sure	Several days	Over 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
Add the score for each column				

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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Patient Name:_____ **Date:**_____
Patient ID #_____

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	**Independence** (1 Point) **NO** supervision, direction or personal assistance.	**Dependence** (0 Points) **WITH** supervision, direction, personal assistance or total care.
BATHING Points: _____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	**(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS: _____ **SCORING:** 6 = High (*patient independent*) 0 = Low (*patient very dependent*

Source:
try this: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

MaineHealth

FALL RISK 65+

Have you fallen in the past year?

Yes / No

Do you use or have you been advised to use a cane or walker to get around safely?

Yes / No

Do you sometimes feel unsteady while walking?

Yes / No

Do you steady yourself by holding onto furniture when walking at home?

Yes / No

Do you worry about falling?

Yes / No

Do you need to push with your hands to stand up from a chair?

Yes / No

Do you have trouble stepping up onto a curb?

Yes / No

Do you often have to rush to the toilet?

Yes / No

Have you lost some feeling in your feet?

Yes / No

Do you take medicine that sometimes makes you light-headed or more tired than usual?

Yes / No

Do you take medicine to help you sleep or improve your mood?

Yes / No

Do you often feel sad or depressed?

Yes / No

Public Health and Travel

Have you been to an area known to be high risk for COVID-19?

Yes / No

In the 14 days before symptom onset, have you had close contact with a laboratory-confirmed COVID-19 while that case was ill?

Yes / No

In the 14 days before symptom onset, have you had close contact with a person who is under investigation for COVID-19 while that person was ill?

Yes / No

Do you reside in or have you traveled to an area where Ebola virus transmission is active?

Yes / No

Have you processed blood or body fluids from an Ebola virus disease patient without appropriate PPE?

Yes / No

Have you recently or are you planning to travel to an area with Zika virus?

Yes / No

Substance Use

Do you or have you ever smoked tobacco?

Yes / No

Do you or have you ever used any other forms of tobacco or nicotine?

Yes / No

What is your level of alcohol consumption?

None/ Occasional/ Moderate Heavy

Do you use any illicit or recreational drugs?

Yes / No

What is your level of caffeine consumption?

None/ Occasional/ Moderate/ Heavy

Home and Environment

Have there been any changes to your family or social situation?

Yes / No

Do you have any pets?

Yes / No

Do you have smoke and carbon monoxide detectors in your home?

Yes / No

Are you passively exposed to smoke?

Yes / No

Do you use insect repellent routinely?

Yes / No

Do you use sunscreen routinely?

Yes / No

Education and Occupation

What is the highest grade or level of school you have completed or the highest degree you have received?

_____

Are you currently employed?

Yes / No

Marriage and Sexuality

What is your relationship status?

Married/ Single/ Divorced/ Separated/ Widowed/ Domestic partner /Other

Are you sexually active?

Yes / No

How many children do you have?_____

Activities of Daily Living

Are you able to care for yourself?

Yes / No

Are you blind or do you have difficulty seeing?

Yes / No

Are you deaf or do you have serious difficulty hearing?

Yes / No

Do you have difficulty concentrating, remembering or making decisions?

Yes / No

Do you have difficulty walking or climbing stairs?

Yes / No

Do you have difficulty dressing or bathing?

Yes / No

Do you have difficulty doing errands alone?

Yes / No

Are you able to walk?

Yes / No

Do you have transportation difficulties?

Yes / No

Lifestyle

Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?

Not at all/ Only a little/ To some extent/ Rather much/ Very much

Do you use your seat belt or car seat routinely?

Yes / No

Diet and Exercise

What type of diet are you following?

Regular/ Vegetarian/ Vegan/ Gluten free/ Specific/ Carbohydrate/ Cardiac/Diabetic

What is your exercise level?

None/Occasional/Moderate/Heavy

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____