TWIN CITIES ORTHOPEDICS

Patient Heath Questionnaire (PHQ-9)

Name:_____ DOB:_____ MRN:_____Date:_____

Over the last two weeks have you been bothered by any of the following problems	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 asleep, 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 or watching television	0	1	2	3
8. Moving or speaking so slowly that others have noticed or the opposite – being	0	1	2	3
more fidgety or restless than usual 9. Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

10. If you checked off any problems, how difficult have these problems made it for you to do you work, take care of things at home or get along with other people:

Not Difficult

Somewhat Difficult

Very Difficult

Extremely Difficult

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Generalized Anxiety Disorder Questionnaire (GAD-7)

Over the last two weeks have you been bothered by any of 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 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

8. 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

Somewhat Difficult

Very Difficult

Extremely Difficult