Patient Health Questionnaire

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that may affect your medical condition and treatment. Please answer every question to the best of your ability unless you are requested to skip over a question.

Today's Date

MM / DD / YY

Gender

☐ Female ☐ Male

Provincial Health Number

First Name

Last Name

1. Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much.	☐	☐	☐	☐
d. Feeling tired or having little energy.	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself - or that you are a failure or have let yourself or family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. 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.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

2. Questions about anxiety.

	NO	YES
a. In the <u>last 4 weeks</u>, have you had an anxiety attack or had a sudden feeling of fear or panic?	☐	☐
b. Has this ever happened before?	☐	☐

3. Over the <u>last 4 weeks</u>, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days
a. Feeling nervous, anxious, on edge, or worrying a lot about different things.	☐	☐	☐
b. Becoming easily annoyed or irritable.	☐	☐	☐
c. Feeling restless so that it is hard to sit still.	☐	☐	☐
d. Muscle tension, aches, or soreness.	☐	☐	☐

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4. Questions about eating.

	NO	YES
a. Do you often feel that you can't control what or how much you eat?	☐	☐
b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐

5. Questions about your drinking habits. Please answer them as they apply over the last 12 months.

a. How often do you have a drink containing alcohol?

☐ Never

☐ Monthly or less

☐ Two to four times a month

☐ Two to three times a week

☐ Four or more times a week

If you checked "never", Go to Question 6.

b. How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 or 2

☐ 3 or 4

☐ 5 or 6

☐ 7 to 9

☐ 10 or more

c. How often do you have six or more drinks on one occasion?

☐ Never

☐ Less than monthly

☐ Monthly

☐ Weekly

☐ Daily or almost daily

d. Has a relative or friend or doctor or other health worker been concerned about your drinking or suggested that you cut down?

☐ No

☐ Yes, but not in the last year

☐ Yes, during the last year

6. In the past 12 months, how often have you used tobacco products?

☐ Never

☐ Once or twice

☐ Monthly

☐ Weekly

☐ Daily or almost daily

7. In the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered	Bothered a little	Bothered a lot
a. Worrying about your health.	☐	☐	☐
b. Worrying about the health of friends or loved ones.	☐	☐	☐
c. Your weight or how you look.	☐	☐	☐
d. Little or no sexual desire or pleasure during sex.	☐	☐	☐
e. Difficulties with husband/wife, partner/lover or boyfriend/girlfriend.	☐	☐	☐
f. The stress of taking care of children, parents, or other family member.	☐	☐	☐
g. Stress at work outside of the home or school.	☐	☐	☐
h. Financial problems or worries.	☐	☐	☐
i. Having no one to turn to for emotional help.	☐	☐	☐
j. Having no one to turn to for practical help, e.g., transportation, household chores.	☐	☐	☐
k. Something bad that happened recently.	☐	☐	☐

8. What is the most stressful thing in your life right now? _____

_____

_____

_____

_____

9. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to take care of your health, e.g., being physically active or eating healthy meals?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

10. Are you taking any prescriptions for anxiety, depression, sleep, or stress?

NO	YES
☐	☐

11. Has a friend, relative or anyone else ever expressed concern about your use of prescription or non precription drugs, eg., sleeping pills, pain killers, diet pills, marijuana etc.?

NO	YES
☐	☐

12. Are you seeing a physician or therapist for any concerns that you identified in this questionnaire?

NO	YES
☐	☐