## The Patient Health Questionnaire (PHQ-9)



Patient Name	Date	e of Visit		
Over the past 2 weeks, 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
Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
<ol> <li>Trouble falling asleep, staying asleep, or sleeping too much</li> </ol>	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're 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	4	. 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
<ol><li>Thoughts that you would be better off dead or of hurting yourself in some way</li></ol>	0	1	2	* 3
Column To	otals	-	+ +	
Add Totals Toge	ther			
10. If you checked off any problems, how difficult have Do your work, take care of things at home, or get a	•			ou to
☐ Not difficult at all ☐ Somewhat difficult ☐ Ve	ry difficult	Ext	remely diffi	cult



## CAGE - Adapted to include Drugs (CAGE-AID) Questionnaire

atien	t Name:		Date:			
1.	Have you ever felt you should <b>C</b> ut down on your drinking or drug use?					
	Drinking: Yes	_ No	Drug Use: Yes	No		
2.	Have people <b>A</b> nnoyed yo					
	Drinking: Yes	_ No	Drug Use: Yes	No		
3.	Have you ever felt bad or	ever felt bad or <b>G</b> uilty about your drinking or drug use??				
	Drinking: Yes	_ No	Drug Use: Yes	No		
4.	Have you ever had a drink nerves or get rid of a han		ng in the morning to	steady your		
	Drinking: Yes	_ No	Drug Use: Yes	No		
		SCORING				
SC	ORE: Number of "Yes" Answe	ers				

MRW 09/01/22

• Screened positive = a score of 1 or greater