**ADOLESCENT Patient Health Questionnaire (PHQ9))**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the last 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** |
| 1. Little interest or pleasure in doing things
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. Feeling down, depressed, or hopeless
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. Trouble falling or staying asleep, or sleeping too much
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. Feeling tired or having little energy
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. Poor appetite, weight loss or overeating
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. Feeling bad about yourself – or that you are a failure or have let yourself or your family down
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. Trouble concentrating on things like school work, reading or watching TV
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. 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* |
| 1. Thoughts that you would be better off dead, or of hurting yourself in some way
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| **Total** |  |  |  |  |
| In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?[ ] Yes [ ] No |
| If you checked off any problems on this questionnaire so far, how **difficult** have these problems made if for you to do your work, take care of things at home, or get along with other people? |
| Not difficult at all🌕 | Somewhat difficult🌕  | Very Difficult🌕  | Extremely Difficult🌕  |
| Has there been a time in the **past month** when you have had serious thoughts about ending your life?[ ] Yes [ ] No |
| Have you EVER, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?[ ] Yes [ ] No |
| \*\*If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911. |

**Generalized Anxiety Disorder Questionnaire (GAD7)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the last 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** |
| 1. Feeling nervous, anxious or on edge
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. Not being able to stop or control worrying
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. Worrying too much about different things
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. Trouble relaxingTrouble relaxingTrouble relaxing Trouble relaxing
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. Being so restless that it is hard to sit still
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. Becoming easily annoyed or irritable
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| 1. Feeling afraid as if something awful might happen
 | 🌕 *0* | 🌕 *1* | 🌕 *2* | 🌕 *3* |
| **Total** |  |  |  |  |
| 1. If you checked off any problems on this questionnaire so far, how difficult have these problems made if for you to do your work, take care of things at home, or get along with other people?
 |
| Not difficult at all🌕  | Somewhat difficult🌕  | Very Difficult🌕  | Extremely Difficult🌕  |