|  |
| --- |
| Name:Date: Last 4 SSN:  |

 **PCL-5**

**Instructions**: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **In the past month, how much were you bothered by:** | **Not at all****0** | **A little****Bit****1** | **Moderately****2** | **Quite** **a bit****3** | **Extremely****4** |
| 1. Repeated, disturbing, and unwanted memories of the stressful experience? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 2. Repeated, disturbing dreams of the stressful experience? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 4. Feeling very upset when something reminded you of the stressful experience? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 6. Avoiding memories, thoughts, or feelings related to the stressful experience? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 8. Trouble remembering important parts of the stressful experience? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 10. Blaming yourself or someone else for the stressful experience or what happened after it? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 11. Having strong negative feelings such as fear, horror, anger, guilt, or shame? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 12. Loss of interest in activities that you used to enjoy? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 13. Feeling distant or cut off from other people? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 15. Irritable behavior, angry outbursts, or acting aggressively? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 16. Taking too many risks or doing things that could cause you harm? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 17. Being “super alert” or watchful or on guard? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 18. Feeling jumpy or easily startled? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 19. Having difficulty concentrating? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 20. Trouble falling or staying asleep? | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

|  |
| --- |
| Name:Date: Last 4 SSN:  |

 **PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use “✔” to indicate your answer)** | **Not at all****0** | **Several days****1** | **More than half the days****2** | **Nearly every day****3** |
| 1 | Little interest or pleasure in doing things | [ ]  | [ ]  | [ ]  | [ ]  |
| 2. Feeling down, depressed, or hopeless | [ ]  | [ ]  | [ ]  | [ ]  |
| 3. Trouble falling or staying asleep, or sleeping too much | [ ]  | [ ]  | [ ]  | [ ]  |
| 4. Feeling tired or having little energy | [ ]  | [ ]  | [ ]  | [ ]  |
| 5. Poor appetite or overeating | [ ]  | [ ]  | [ ]  | [ ]  |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | [ ]  | [ ]  | [ ]  | [ ]  |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | [ ]  | [ ]  | [ ]  | [ ]  |
| 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 | [ ]  | [ ]  | [ ]  | [ ]  |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | [ ]  | [ ]  | [ ]  | [ ]  |

**FOR OFFICE CODING 0 + \_\_\_\_\_\_ + \_\_\_\_\_\_ + \_\_\_\_\_\_**

**=Total Score: \_\_\_\_\_\_**

|  |
| --- |
| **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 at all** **[ ]**  | **Somewhat difficult****[ ]**  | **Very difficult** **[ ]** | **Extremely difficult****[ ]**  |

**Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display, or distribute.**

|  |
| --- |
| Name:Date: Last 4 SSN:  |

 **GAD-7 Anxiety**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the last two weeks, how often have you been bothered by the following problems? | Not at all0 | Several days1 | More than half the days2 | Nearly every day3 |
| 1. Feeling nervous, anxious, or on edge
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Not being able to stop or control worrying
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Worrying too much about different things
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Trouble relaxing
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Being so restless that it is hard to sit still
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Becoming easily annoyed or irritable
 | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Feeling afraid, as if something awful might happen
 | [ ]  | [ ]  | [ ]  | [ ]  |

Column totals \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

= Total score \_\_\_\_\_\_\_

|  |
| --- |
| If you checked any problems, how difficult have they made it 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 …****[ ]**  |

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

**Scoring GAD-7 Anxiety Severity**

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.” GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety