PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Date of Birth:** _____ **Provider:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling:

	(0) Not at all	(1) Several Days	(2) More than half the days	(3) Nearly every day
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, irritable, or hopeless?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Feeling tired, or having little energy				
5. Poor appetite, weight loss, or overeating?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? □ Yes □ No

If you are experiencing any problems on this form, 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

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 hurting yourself in some way, please discuss this with your provider, go to a hospital emergency room, or call 911.

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Modified with permission from PHQ (Spitzer, Williams & Kroenke, 1999) by J Johnson (Johnson, 2002)

PLEASE TURN OVER AND COMPLETE OTHER SIDE OF FORM

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all (0)	Several days (1)	Over half the days (2)	Nearly everyday (3)
1. Feeling nervous, anxious, or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still.				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				

If you checked off any problems, how difficult have these 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_____

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Source: Spizer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med*. 2006; 166:1092-0197.

The SCOFF Questionnaire

Do you make yourself sick because you feel too full?	Yes	No
Do you worry you have lost control over how much you eat?	Yes	No
Have you recently lost over 14 pounds (in the last 3 months)?	Yes	No
Do you believe yourself to be fat when others say you are too thin?	Yes	No
Would you say that food dominates your life?	Yes	No

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Source: Adapted for American population from Morgan, Reid, and Lacey 1999