

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	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	<input checked="" type="radio"/> 0	1	2	3
2. Feeling down, depressed, or hopeless	<input checked="" type="radio"/> 0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	<input checked="" type="radio"/> 2	3
4. Feeling tired or having little energy	<input checked="" type="radio"/> 0	1	2	3
5. Poor appetite or overeating	<input checked="" type="radio"/> 0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	<input checked="" type="radio"/> 0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	<input checked="" type="radio"/> 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	<input checked="" type="radio"/> 0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	<input checked="" type="radio"/> 1	2	3

FOR OFFICE CODING 0 + 1 + 2 + 1
=Total Score: 3

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
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mental Status Exam

Client Name <u>Madden</u>		Date <u>2-17-2023</u>	
OBSERVATIONS			
Appearance	<input checked="" type="checkbox"/> Neat	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Inappropriate <input type="checkbox"/> Bizarre <input type="checkbox"/> Other
Speech	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Tangential	<input type="checkbox"/> Pressured <input type="checkbox"/> Impoverished <input type="checkbox"/> Other
Eye Contact	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Intense	<input type="checkbox"/> Avoidant <input type="checkbox"/> Other
Motor Activity	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Restless	<input type="checkbox"/> Tics <input type="checkbox"/> Slowed <input type="checkbox"/> Other
Affect	<input checked="" type="checkbox"/> Full	<input type="checkbox"/> Constricted	<input type="checkbox"/> Flat <input type="checkbox"/> Labile <input type="checkbox"/> Other
Comments:			
MOOD			
<input type="checkbox"/> Euthymic <input checked="" type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input type="checkbox"/> Other			
Comments:			
COGNITION			
Orientation Impairment	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Place	<input checked="" type="checkbox"/> Object <input checked="" type="checkbox"/> Person <input type="checkbox"/> Time
Memory Impairment	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Short-Term	<input type="checkbox"/> Long-Term <input type="checkbox"/> Other
Attention	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Distracted	<input type="checkbox"/> Other
Comments:			
PERCEPTION			
Hallucinations	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Auditory	<input type="checkbox"/> Visual <input type="checkbox"/> Other
Other	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Derealization	<input type="checkbox"/> Depersonalization
Comments:			
THOUGHTS			
Suicidality	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Ideation	<input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Self-Harm
Homicidality	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Intent <input type="checkbox"/> Plan
Delusions	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Paranoid <input type="checkbox"/> Religious <input type="checkbox"/> Other
Comments:			
BEHAVIOR			
<input type="checkbox"/> Cooperative	<input type="checkbox"/> Guarded	<input checked="" type="checkbox"/> Hyperactive	<input type="checkbox"/> Agitated <input type="checkbox"/> Paranoid
<input type="checkbox"/> Stereotyped	<input checked="" type="checkbox"/> Aggressive	<input type="checkbox"/> Bizarre	<input type="checkbox"/> Withdrawn <input type="checkbox"/> Other
Comments:			
INSIGHT	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Poor
Comments:			
JUDGMENT	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Poor
Comments:			