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SANFORD HEALTH
Behavioral Health

Client # _____

Adult: Health Questionnaire / PHQ-9

Client Name: _____

For each question, please answer all items as best you can. Place a "0, 1, 2 or 3" in the appropriate box.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead or of hurting yourself in some way				
For Office Coding Totals:	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

Client Signature _____ Date _____

Revised 03/24/2020

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SANFORD HEALTH
Behavioral Health

Client # _____

Adult: Generalized Anxiety Disorder 7-Item (GAD-7) Scale

Client Name: _____

For each question, please answer all items as best you can. Place a "0, 1, 2 or 3" in the appropriate box.

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 every day (3)
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				
For office coding totals				

*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

Client Signature _____ Date _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure of assessing generalized anxiety disorder. *Arch Inern Med. 2006; 166:1092-1097.*

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SANFORD HEALTH
Behavioral Health

Client # _____

(WHODAS 2.0) World Health Organization Disability Assessment Schedule 2.0

Client Name: _____

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs. Think back over the **past 30 days** and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please select only **one response**.

In the past 30 days, how much difficulty did you have in:	**None (1)**	**Mild (2)**	**Moderate (3)**	**Severe (4)**	**Extreme or Cannot Do (5)**
Standing for long periods such as 30 minutes?					
Taking care of your household responsibilities?					
Learning a new task, for example, learning how to get to a new place?					
How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?					
How much have you been emotionally affected by your health problems?					
Concentrating on doing something for ten minutes?					
Walking a long distance such as a kilometer [or equivalent]? 1 kil = .62 miles					
Washing your whole body?					
Getting dressed?					
Dealing with people you do not know?					
Maintaining a friendship?					
Your day-to-day work?					
Total Item Score					

Overall, in the past 30 days, how many days were these difficulties present?	*Record number of days* _____
In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	*Record number of days* _____
In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	*Record number of days* _____

Client Signature _____ **Date** _____