Annual Mental Health Questionnaire

KAISER PERMANENTE®

Patient Label

Name:_____

MRN: _____

Date: _____

Once a year, we ask all our patients to complete this form on conditions that affect their health. Please help us provide you with the best medical care by answering the questions below.

Please CIRCLE the BEST response to each question.

Over the past 2 weeks, how often have you been bothered by any of the following problems:

1. Little interest or pleasure in doing things?	**Not at all** 0	**Several days** 1	**More than half the days** 2	**Nearly every day** 3
2. Feeling down, depressed, or hopeless?	**Not at all** 0	**Several days** 1	**More than half the days** 2	**Nearly every day** 3

In the past year…

3. How often did you have a drink containing alcohol in the past year?	**Never** 0	**Monthly or less** 1	**2 to 4 times a month** 2	**2 to 3 times a week** 3	**4 or more times a week** 4
4. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?	**None** 0	**1 or 2 drinks** 0	**3 or 4 drinks** 1	**5 or 6 drinks** 2	**7 to 9 drinks** 3	**10 or more drinks** 4
5. How often did you have 6 or more drinks on one occasion in the past year?	**Never** 0	**Less than monthly** 1	**Monthly** 2	**Weekly** 3	**Daily or almost daily** 4
6. How often in the past year have you used cannabis (THC-containing products)?	**Never** 0	**Less than monthly** 1	**Monthly** 2	**Weekly** 3	**Daily or almost daily** 4
7. How often in the past year have you used an illegal drug (not cannabis) or used a prescription medication for non-medical reasons?	**Never** 0	**Less than monthly** 1	**Monthly** 2	**Weekly** 3	**Daily or almost daily** 4

PHQ-9 for ADULTS*
Patient Health Questionnaire

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

The following questions will help us understand how you've been feeling. Your answers will help you and your doctor follow your progress.			
1. At any point in your life, have you gone through periods when you felt the opposite of being depressed – very 'high' or 'speeded up', with lots of energy? Didn't need sleep? Felt you could do anything? Circle **Yes** if you had these symptoms and they lasted at least a few days and caused trouble for you in your life.	Yes	No	N/A
2. In the past 2 weeks, have you heard or seen things that other people couldn't see or hear that might really not be there?	Yes	No	N/A
3. Have you recently been the victim of threats, physical hurting, or forced sexual contact?	Yes	No	N/A
4. Have you recently experienced some stressful event or life change, like the death of a friend or family member, loss of job, or relationship problems?	Yes	No	N/A
5. In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the past month you: • Have had nightmares about it or thought about it when you did not want to? • Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? • Were constantly on guard from others, activities, or your surroundings?	Yes	No	N/A

*This is a standardized 9-item questionnaire that has been validated. Questions #1 and #2 have been removed because they are the first two questions on the Behavioral Health screen (see other side), which have already been answered.

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc.

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