Annual Behavioral Health Questionnaire

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 marijuana?	**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 marijuana) 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

*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.