Wellness - PHQ9 + GAD7

Date: ____/____/20____

Patient Name:		**DOB:**	

PHQ-9

Over the ***last 2 weeks***, how often have you been bothered by any of the following problems? (Please put a check mark for your answer) ✓	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless?	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Feeling tired or having little energy?	☐	☐	☐	☐
5. Poor appetite or overeating?	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
8. thoughts that you would be better off dead or of hurting yourself in some way?	☐	☐	☐	☐
9. 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?	☐	☐	☐	☐
***Staff Use Only below this line:**	**0**	**1**	**2**	**3**
Add the score for each column				
Total Score =				

GAD-7

Over the ***last 2 weeks***, how often have you been bothered by any of the following problems? (Please put a check mark for your answer) ✓	Not at all	Several days	Over half the days	Nearly every day
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's hard to sit still.	☐	☐	☐	☐
6. Becoming easily annoyed or irritated.	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen.	☐	☐	☐	☐
***Staff Use Only below this line:**	**0**	**1**	**2**	**3**
Add the score for each column				
Total Score =				

Wellness Screening Forms

Date: ____/____/20____

Patient Name:		**DOB:**	

Date of your last Wellness visit? ____ /____ / 20____

How are you feeling today? _____

Have you recently experienced issues with depression or anxiety? **Yes** ☐ **No** ☐

Do you have family/friends that are available to help if needed? **Yes** ☐ **No** ☐

Have you had any falls during the last 12 months? **Yes** ☐ **No** ☐

If yes, how many? _____ Were you injured? **Yes** ☐ **No** ☐

Were you hospitalized in the last 12 months? **Yes** ☐ **No** ☐ If yes, how many times? _____

Hospital Name: _____ Date: _____

Hospital Name: _____ Date: _____

Have you seen any other doctors in the past 12 months?

Name: _____ Specialty: _____ Phone #: _____

Name: _____ Specialty: _____ Phone #: _____

Name: _____ Specialty: _____ Phone #: _____

Do you….	**Check**	**If yes….**
Smoke?	☐ Yes ☐ No	How many per day?
Drink?	☐ Yes ☐ No	How many drinks per week?
Recreational Drug?	☐ Yes ☐ No	Type: How many times weekly?
Exercise?	☐ Yes ☐ No	Type: How many times weekly?

Please write the last date for each…					
Flu Shot		Bone Density		*Female Only (answer below)*	
Prevnar Vaccine		Colonoscopy		Mammo	
Pneumo Vaccine		Eye Exam		Pap Smear	
Shingles Vaccine					

Has anyone ever discussed advance directives with you? **Yes** ☐ **No** ☐

If you have any advance directives, have you provided us with a copy? **Yes** ☐ **No** ☐