

PHQ-A



Name: Jane Doe
ID Number: 123456789
Gender: Female
Date: 12/4/2007 9:39:00 AM

Reviewed by: _____
Age: 17
Race: White

PHQ-A Summary - Provisional Diagnostic Items

Suicidal Ideation **Yes**
BMI **29.53**
BMI Range Score **Individuals with a BMI between 25.01 and 29.99 are overweight**

Depression and Mood		
1.	Little interest or pleasure in doing things?	YES: A few days in the past 2 weeks
2.	Feeling down, depressed, irritable or hopeless?	NO
3.	Trouble falling asleep, staying asleep, or sleeping too much?	YES: A few days in the past 2 weeks
4.	Feeling tired or having little energy?	YES: A few days in the past 2 weeks
5.	Poor appetite, weight loss, or overeating?	YES: Nearly every day in the past 2 weeks
6.	Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down?	YES: Nearly every day in the past 2 weeks
7.	Trouble concentrating on things like school work, reading, or watching TV?	YES: Nearly every day in the past 2 weeks
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you were moving around a lot more than usual?	YES: A few days in the past 2 weeks
9.	Have you felt sad, upset, irritable, or depressed on MORE THAN HALF OF THE DAYS IN THE PAST YEAR?	Yes
10.	IN THE PAST YEAR, have you felt so sad, upset, irritable, or depressed that it has often been hard for you to do your work, take care of things at home, or get along with other people?	Yes
11.	IN THE PAST YEAR, has there been a time when you didn't feel sad, upset, irritable, or depressed for TWO MONTHS IN A ROW or longer? That is, has there been a time in the past year when you felt happy most of the time for at least TWO MONTHS IN A ROW?	Yes
12.	IN THE LAST 2 WEEKS, have you often felt hopeless about the future?	No
13.	IN THE LAST 2 WEEKS, have you often had thoughts that you would be better off dead, or of hurting yourself in some way?	Yes
14.	Has there been a time in the past month when you have had serious thoughts about ending your life?	No
15.	In the past 2 weeks, have you been so sad, down, irritable, or depressed that it has been difficult for you to do your work, take care of things at home, or get along with other people?	Not difficult at all

Fear and Anxiety		
16.	IN THE LAST MONTH, have you had an anxiety attack, when you suddenly felt fear or panic?	Yes
17.	Have you had any other anxiety attacks like this IN THE PAST YEAR?	No
18.	Do these feelings of panic sometimes come SUDDENLY OUT OF THE BLUE - that is, in situations where you don't expect to be nervous or uncomfortable?	No
19.	Do you OFTEN worry about having these anxiety attacks? Or, have you had to change your behavior or your lifestyle to avoid having more attacks?	No
20.	Were you short of breath?	No
21.	Did your heart race, pound, or skip?	No
22.	Did you have chest pain or pressure?	Yes
23.	Did you sweat?	Yes
24.	Did you feel as if you were choking?	No
25.	Did you have hot flashes or chills?	Yes
26.	Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	Yes
27.	Did you feel dizzy, unsteady, or faint?	Yes
28.	Did you have tingling or numbness in parts of your body?	No
29.	Did you tremble or shake?	Yes
30.	Were you afraid that you were going crazy or losing control?	Yes
31.	Were you afraid that you were dying?	Yes
32.	Have you felt nervous, anxious, or on edge, or have you worried a lot ON MORE THAN HALF THE DAYS IN THE LAST SIX MONTHS?	Yes
33.	Have you been worrying A LOT about MANY DIFFERENT KINDS OF THINGS in the last six months?	Yes
34.	Do you OFTEN find that it's VERY DIFFICULT to stop worrying?	Yes
35.	Feeling restless so that it is hard to sit still?	YES: Less than half the days in the past 6 months.
36.	Getting tired very easily?	YES: More than half the days in the past 6 months.
37.	Muscle tension, aches, or soreness?	YES: Less than half the days in the past 6 months.
38.	Trouble falling asleep or staying asleep?	YES: More than half the days in the past 6 months.
39.	Trouble concentrating on things such as school work, reading, or watching TV?	YES: Less than half the days in the past 6 months.
40.	Becoming easily annoyed or irritable?	YES: More than half the days in the past 6 months.
41.	How much have problems with fear or anxiety made it difficult for you to do your work, take care of things at home, or get along with other people?	Not difficult at all

Alcohol and Cigarettes		
In the last 6 months		
42.	Have there been any days in the past six months when you had five or more drinks of beer, wine or liquor?	NO
43.	Have there been any days in the past six months when you drank so much beer, wine or liquor that you got drunk or more than a little tipsy?	YES: 1 or 2 days
44.	Have you been drinking alcohol, drunk or tipsy from alcohol, or hung over while you were working, studying, going to school, or taking care of other responsibilities?	YES (more than once)
45.	Have you missed or been late for school, work, or other responsibilities because you were drinking or hung over?	NO
46.	Have you driven a car when you were drunk or tipsy from alcohol, or after having several drinks?	YES (once)
47.	Have you had any problems getting along with other people while you were drinking or because of your alcohol use?	NO
48.	In the past 6 months, has anyone complained about your alcohol use, or told you that you have a drinking problem?	NO
49.	Has a doctor ever said that you should stop drinking for health reasons?	NO
50.	Have you had any legal problems because of your alcohol use?	NO
51.	Do you feel guilty or upset about your use of alcohol, or do you think that you drink too much, or that you might have an alcohol problem?	NO
52.	How many cigarettes would you say that you have smoked ON AN AVERAGE DAY in the past month?	None

Drug Use		
53.	Have you used marijuana ("grass," "pot," "weed," or "hash") in the past 6 months?	YES
54.	Have you used cocaine or "crack" in the past 6 months?	NO
55.	Have you used "ecstasy," mushrooms, LSD, "acid," or other hallucinogenic drugs in the past 6 months?	NO
56.	In the past 6 months, have you used any other drugs to get high, including stimulants ("speed"), tranquilizers, or pain killers such as codeine or heroin?	NO
57.	In the past 6 months, have you sniffed glue or inhaled sprays or paints to get high?	NO
58.	How often have you used these or other kinds of drugs to get high in the past 6 months?	Once
59.	Have you used drugs, or were you high or hung over from drug use while you were going to school, working, studying, or taking care of other responsibilities?	YES (more than once)
60.	Have you missed or were late for school, work, or other responsibilities because you were using drugs?	YES (once)
61.	Have you driven a car when you were "high" from drug use?	YES (more than once)
62.	Have you had any problems getting along with other people while you were using drugs or because of your drug use?	NO
63.	In the past 6 months, has anyone complained about your drug use, or told you that you have a drug problem?	YES
64.	Has a doctor ever said that you should stop using drugs for health reasons?	NO
65.	Have you had any legal problems because of your drug use?	YES
66.	Do you feel guilty or upset about your drug use, or do you think that you use drugs too often, or that you might have a drug problem?	NO

Eating and Weight		
67.	How much do you weigh? (pounds)	200
68.	How tall are you? (feet) (inches) pounds	05 feet 09 inches
69.	Do you think that you are too heavy, and that you should try to lose weight?	YES
70.	Do you often worry a great deal about gaining weight or becoming fat?	YES
71.	Does your weight or body shape VERY STRONGLY affect the way you feel about yourself?	YES
72.	Do you often feel that you can't control what or how much you eat?	YES
73.	Do you sometimes eat what most people would regard as an unusually large amount of food within a 2-hour period?	YES
74.	Have you eaten very large amounts of food like this at least as twice a week, in an average week, for the past 6 months?	NO
75.	Have you exercised ALMOST EVERY DAY FOR OVER AN HOUR to lose or avoid gaining weight?	YES
76.	Have you used diet drugs almost every day for months to lose or avoid gaining weight?	YES
77.	Have you fasted (not eaten anything) for at least 24 hours to lose or avoid gaining weight?	NO
78.	Have you used high doses of laxatives or diuretics to lose or avoid gaining weight?	YES
79.	Have you made yourself vomit to lose weight or to avoid gaining weight?	YES
80.	Have you used enemas to lose weight or to avoid gaining weight?	YES
81.	How often have you done things like this to avoid gaining weight IN THE LAST 3 MONTHS?	Never
82.	Have you had any menstrual periods in the past 3 months?	YES
83.	How much have any problems that you may have had with your eating habits or your weight made it difficult for you to do your work, take care of things at home, or get along with other people?	Not difficult at all