PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

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

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 _____

A2663B 10-04-2005

PATIENT NAME : _____ DATE _____

Vulnerable Elders Survey (VES) 13 Scale

DOMAIN	Score
75-85	1
>85	3
Self Rated Health	
Good, Very good, and excellent	0
Fair and Poor	1
Activities of daily living(ADL)/ instrumental activities of daily living(IADL)	
I NEED ASSISTANCE WITH:	
Bathing or Showering	1
Shopping	1
Money Management	1
Transfer	1
Light housework	1

I have difficulty in special activities:	
Kneeling, bending, and stooping	1
Performance of housework(example: scrubbing the floor)	1
Reaching out and lifting upper extremities above the shoulder	1
Lifting and carrying 10 lbs	1
Walking ¼ of a mile	1
Writing or handling and grasping small objects	1

Total Score _____

NAME: _____ DOB:_____ DATE:_____

CURRENT LIST OF PROVIDERS AND MEDICAL SUPPLIERS

Physicians/Physician Assistants/Nurse Practitioners involved in my care:

_____

_____

_____

_____

_____

Pharmacies that I use most often:

_____

_____

_____

Therapist for physical therapy, occupational therapy, psychological therapy:

_____

_____

_____

Suppliers for my medical equipment such as oxygen, wheelchair, CPAP device:

_____

_____

_____

Other providers or suppliers not mentioned above:

_____

_____