NAME:____ Date: ____________________

OVER LAST TWO DAYS	Not at all	Several Hours	More than half of time.	Nearly All the time.
Little interest or pleasure in doing things:	0	1	2	3
Feeling down, depressed, or hopeless:	0	1	2	3
Trouble falling or staying asleep/ sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
Self-Destructive Self-Harm Behavior /Thoughts	0	1	2	3
Using Alcohol and Drugs	0	1	2	3
Isolating away from friends and family	0	1	2	3
Poor Sleep/ Wake Cycle	0	1	2	3
Significant Side Effects to Medication	0	1	2	3
Not Following Instructions Regarding Treatment	0	1	2	3
Disturbances in Reality (Hallucinations, Paranoia, Strong obsessions)	0	1	2	3
Significant anxiety that affects functioniong.	0	1	2	3

NAME:____Date: _______________________

HOW ARE YOU?

ARE THERE ANY NEW UPDATES SINCE LAST VISIT?

ANY SPECIFIC OR IMPORTANT COMMENTS REGARDING THE SCALE ABOVE (PHQ 9 +)

HOW DO YOU RATE YOUR CARE HERE ON A SCALE OF 1 TO 10? ANYTHING WE CAN DO TO IMPROVE IT?

ANY ADDITIONAL THINGS YOU WOULD LIKE TO DISCUSS TODAY?

ARE YOU AWARE OF OUR PROGRAMS POLICIES AND GENERAL INSTRUCTIONS AND WHERE THEY ARE LOCATED?

PATIENT SIGNATURE

____

NAME:____ Date: ____________________