

Pain and Disability Scales

Brief Pain Inventory (BPI)

Neuropathic pain

Leeds Assessment of Neuropathic Symptoms and Signs S-LANSS)

Douleur Neuropathique en 4 Questions (DN4)

Tampa Kinesiophobia Scale (TKS)

Pain Self Efficacy Questionnaire (PSEQ)

Pain Catastrophizing Scale (PCS)

Neck Disability Index

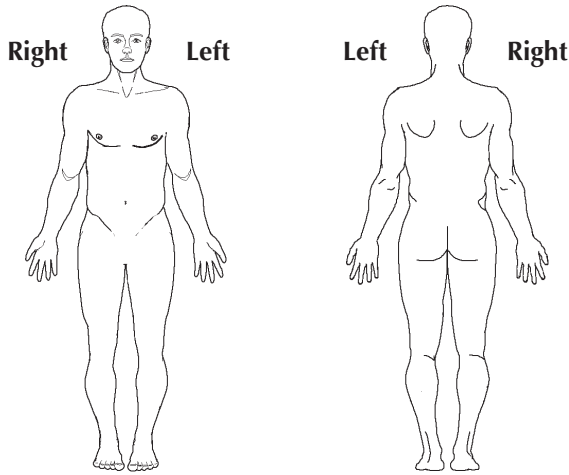
Oswestry Low Back Disability Questionnaire

BRIEF PAIN INVENTORY

Date ____/____/____ Time: _____

Name: _____
Last First Middle Initial

- Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
 1. Yes 2. No
- On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



- Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

No Pain Pain as bad as you can imagine
- Please rate your pain by circling the one number that best describes your pain at its LEAST in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

No Pain Pain as bad as you can imagine
- Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

No Pain Pain as bad as you can imagine
- Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

No Pain Pain as bad as you can imagine

- What treatments or medications are you receiving for your pain?

- In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0% 10 20 30 40 50 60 70 80 90 100%

No relief

Complete relief

- Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere

Completely interferes

In addition to completing the Brief Pain Inventory, to help your doctor better manage your pain, please tell us:

What does the pain feel like? Circle those words that describe your pain.

aching	throbbing	shooting
stabbing	gnawing	pricking
sharp	tender	burning
exhausting	tiring	penetrating
nagging	numb	miserable
unbearable	dull	radiating
squeezing	cramping	deep

How long have you had this pain? (Circle one)

less than a week	1 to 2 weeks
2 to 4 weeks	more than a month

What kinds of things make your pain feel better (for example, heat, medicine, rest)?

What kinds of things make your pain worse (for example, walking, standing, lifting)?

Do you have any other symptoms? Circle any that apply:

nausea	vomiting
constipation	diarrhea
lack of appetite	indigestion
difficulty sleeping	feeling drowsy
nightmares	dizziness
tiredness	itching
urinary problems	sweating
weakness	headaches

Talking About Your Pain

It's important to remember that each person's pain is different. The pain that you experience can't be compared to another person's pain. ONLY YOU know how and when you hurt, and how the pain affects your life.

It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your doctor, nurse, or pharmacist. They need to know as much as possible about your pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

Why Is Pain Relief So Important?

Proper treatment for pain is not only a matter of comfort. Unrelieved pain can lead to nausea, loss of sleep, depression, loss of appetite, weakness, and other problems. Pain can also affect your life at home and at work. Relieving your pain means that you can continue to do the day-to-day things that are important to you.

Most Pain Can Be Controlled

It is important to know that most pain CAN be relieved. Your doctor will work with you to find the treatment that may be best for your pain.

The key to effective pain control is to take the RIGHT AMOUNT, of the RIGHT MEDICINE, at the RIGHT TIME. You should take your pain medicine on a regular schedule, as your doctor, nurse, or pharmacist tells you. Don't wait until the pain becomes severe. Pain is easier to control when it is mild than when it has reached full force.

If your pain medicine wears off too soon, is not relieving the pain, or causes problems with side effects, you should call your doctor because you may need to have your treatment plan changed.

Comments: Write down any questions or information you need to share with your doctor, nurse, or pharmacist about your pain.

THE S-LANSS PAIN SCORE

1. **In the area where you have pain, do you also have “pins and needles”, tingling or prickling sensations?**
 - a) NO- I don’t get these sensations (0)
 - b) YES- I get these sensations (5)

2. **Does the painful area change colour (perhaps look mottled or more red) when the pain is particularly bad?**
 - a) NO- The pain does not affect the colour of my skin (0)
 - b) YES-I have noticed that the pain does make my skin look different from normal. (5)

3. **Does your pain make the affected skin abnormally sensitive to touch? Getting unpleasant sensations or pain when lightly stroking the skin might describe this.**
 - a) NO- The pain does not make my skin abnormally sensitive to touch. (0)
 - b) YES- My skin in that area is particularly sensitive to touch. (3)

4. **Does your pain come on suddenly and in bursts for no apparent reason when you are completely still? Words like “electric shocks”, jumping and bursting might describe this.**
 - a) NO- My pain doesn’t really feel like this. (0)
 - b) YES- I get these sensations often. (2)

5. **In the area where you have pain, does your skin feel unusually hot like a burning pain?**
 - a) NO- I don’t have burning pain (0)
 - b) YES- I get burning pain often (1)

6. **Gently rub the painful area with your index finger and then rub a non-painful area (for example, an area of skin further away or on the opposite side from the painful area). How does this rubbing feel in the painful area?**
 - a) The painful area feels no different from the non-painful area (0)
 - b) I feel discomfort, like pins and needles, tingling or burning in the painful area that is different from the non-painful area. (5)

7. **Gently press on the painful area with your finger tip and then gently press in the same way onto a non-painful area (the same non-painful area that you chose in the last question). How does this feel in the painful area?**
 - a) The painful area does not feel different from the non-painful area. (0)
 - b) I feel numbness or tenderness in the painful area that is different from the non-painful area. (3)

Scoring a score of 12 or more suggests pain of predominantly neuropathic origin

DN4 – QUESTIONNAIRE

To estimate the probability of neuropathic pain, please answer yes or no for each item of the following four questions.

INTERVIEW OF THE PATIENT

QUESTION 1:

Does the pain have one or more of the following characteristics? YES NO

Burning YES NO

Painful cold YES NO

Electric shocks YES NO

QUESTION 2:

Is the pain associated with one or more of the following symptoms in the same area? YES NO

Tingling YES NO

Pins and needles YES NO

Numbness YES NO

Itching YES NO

EXAMINATION OF THE PATIENT

QUESTION 3:

Is the pain located in an area where the physical examination may reveal one or more of the following characteristics? YES NO

Hypoesthesia to touch YES NO

Hypoesthesia to pinprick YES NO

QUESTION 4:

In the painful area, can the pain be caused or increased by: YES NO

Brushing? YES NO

YES = 1 point

NO = 0 points

Patient's Score: /10

TSK

Client No.: _____

Age: _____

Sex: M() F()

Date: _____

Instructions

Please read each of the following statements and circle the number that better represents your feelings

Strongly disagree
Somewhat disagree
Somewhat agree
Strongly agree

-
- | | | | | |
|---|---|---|---|---|
| 1. I'm afraid that I might injure myself if I exercise | 1 | 2 | 3 | 4 |
| 2. If I were to try to overcome it, my pain would increase | 1 | 2 | 3 | 4 |
| 3. My body is telling me I have something dangerously wrong | 1 | 2 | 3 | 4 |
| 4. People aren't taking my medical condition seriously enough | 1 | 2 | 3 | 4 |
| 5. My accident has put my body at risk for the rest of my life | 1 | 2 | 3 | 4 |
| 6. Pain always means I have injured my body | 1 | 2 | 3 | 4 |
| 7. Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening | 1 | 2 | 3 | 4 |
| 8. I wouldn't have this much pain if there weren't something potentially dangerous going on in my body | 1 | 2 | 3 | 4 |
| 9. Pain lets me know when to stop exercising so that I don't injure myself | 1 | 2 | 3 | 4 |
| 10. I can't do all the things normal people do because it's too easy for me to get injured | 1 | 2 | 3 | 4 |
| 11. No one should have to exercise when he/she is in pain | 1 | 2 | 3 | 4 |
-

PAIN SELF EFFICACY QUESTIONNAIRE (PSEQ)
M.K.Nicholas (1989)

NAME: _____ DATE: _____

Please rate how **confident** you are that you can do the following things at present, **despite the pain**. To indicate your answer circle **one** of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.

For example:

0 1 2 3 4 5 6
Not at all Completely
Confident confident

Remember, this questionnaire is **not** asking whether of not you have been doing these things, but rather **how confident you are that you can do them at present, despite the pain.**

1. I can enjoy things, despite the pain.

0 1 2 3 4 5 6
Not at all Completely
Confident confident

2. I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.

0 1 2 3 4 5 6
Not at all Completely
Confident confident

3. I can socialise with my friends or family members as often as I used to do, despite the pain.

0 1 2 3 4 5 6
Not at all Completely
Confident confident

4. I can cope with my pain in most situations.

0 1 2 3 4 5 6
Not at all Completely
Confident confident

Turn over

Pain Catastrophizing Scale

Sullivan MJL, Bishop S, Pivik J. (1995)

Name:

Age:

Gender:

Date:

Male Female

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

Instructions:

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

RATING	0	1	2	3	4
MEANING	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

When I'm in pain ...

Number	Statement	Rating
1	I worry all the time about whether the pain will end.	
2	I feel I can't go on.	
3	It's terrible and I think it's never going to get any better	
4	It's awful and I feel that it overwhelms me.	
5	I feel I can't stand it anymore	
6	I become afraid that the pain will get worse.	
7	I keep thinking of other painful events	
8	I anxiously want the pain to go away	
9	I can't seem to keep it out of my mind	
10	I keep thinking about how much it hurts.	
11	I keep thinking about how badly I want the pain to stop	
12	There's nothing I can do to reduce the intensity of the pain	
13	I wonder whether something serious may happen.	

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself, and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self -care.
- I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- I can lift heavy weights without causing extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

SECTION 4 - WORK

- I can do as much work as I want.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I can't do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

SECTION 5 - HEADACHES

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

SECTION 6 - CONCENTRATION

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

SECTION 7 - SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hour.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 - DRIVING

- I can drive my car without neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can't drive as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive my care at all because of neck pain.

SECTION 9 - READING

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I can't read as much as I want because of moderate neck pain.
- I can't read as much as I want because of severe neck pain.
- I can't read at all.

SECTION 10 - RECREATION

- I have no neck pain during all recreational activities.
- I have some neck pain with all recreational activities.
- I have some neck pain with a few recreational activities.
- I have neck pain with most recreational activities.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

PATIENT NAME _____

DATE _____

SCORE _____ [50]

BENCHMARK -5 = _____

Modified Oswestry Low Back Pain Disability Questionnaire

Name: _____ Date: ____/____/____

Please Read:

This questionnaire has been designed to give your doctor/therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the **one** box that best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition

<p>Section 1 – Pain Intensity</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can tolerate the pain I have without having to use pain medication. <input type="checkbox"/> The pain is bad but I manage without having to take pain medication. <input type="checkbox"/> Pain medication provides me complete relief from pain. <input type="checkbox"/> Pain medication provides me moderate relief from pain. <input type="checkbox"/> Pain medication provides me little relief from pain. <input type="checkbox"/> Pain medication has no effect on the pain 	<p>Section 6 – Standing</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can stand as long as I want without increased pain. <input type="checkbox"/> I can stand as long as I want but increases my pain. <input type="checkbox"/> Pain prevents me from standing for more than 1 hour. <input type="checkbox"/> Pain prevents me from standing for more than ½ hour. <input type="checkbox"/> Pain prevents me from standing for more than 10 mins. <input type="checkbox"/> Pain prevents me from standing at all.
<p>Section 2 – Personal Care (Washing, Dressing, etc.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can take care of myself normally without causing increased pain. <input type="checkbox"/> I can take care of myself normally but it increases my pain. <input type="checkbox"/> It is painful to take care of myself and I am slow and careful. <input type="checkbox"/> I need help but I am able to manage most of my personal care. <input type="checkbox"/> I need help every day in most aspects of my care. <input type="checkbox"/> I do not get dressed, wash with difficulty and stay in bed. 	<p>Section 7 – Sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain does not prevent me from sleeping well. <input type="checkbox"/> I can sleep well only by using pain medication. <input type="checkbox"/> Even when I take pain medication, I sleep less than 6 hours. <input type="checkbox"/> Even when I take pain medication, I sleep less than 4 hours. <input type="checkbox"/> Even when I take pain medication, I sleep less than 2 hours. <input type="checkbox"/> Pain prevents me from sleeping at all
<p>Section 3 – Lifting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without increased pain. <input type="checkbox"/> I can lift heavy weights but it causes increased pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can lift only very light weights. <input type="checkbox"/> I cannot lift or carry anything at all. 	<p>Section 8 – Social Life</p> <ul style="list-style-type: none"> <input type="checkbox"/> My social life is normal and does not increase my pain. <input type="checkbox"/> My social life is normal, but it increases my level of pain. <input type="checkbox"/> Pain prevents me from participating in more energetic activities (ex sports, dancing, etc. <input type="checkbox"/> Pain prevents me from going out very often. <input type="checkbox"/> Pain has restricted my social life to my home. <input type="checkbox"/> I have hardly any social life because of my pain.
<p>Section 4 - Walking</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain does not prevent me walking any distance. <input type="checkbox"/> Pain prevents me walking more than 1 mile. <input type="checkbox"/> Pain prevents me walking more than ½ mile <input type="checkbox"/> Pain prevents me walking more than ¼ mile <input type="checkbox"/> I can only walk using crutches or a cane. <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet. 	<p>Section 9 – Traveling</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can travel anywhere without increased pain. <input type="checkbox"/> I can travel anywhere but it increases my pain. <input type="checkbox"/> Pain restricts travel over 2 hours. <input type="checkbox"/> Pain restricts travel over 1 hour. <input type="checkbox"/> Pain restricts my travel to short necessary journeys under ½ hour. <input type="checkbox"/> Pain prevents all travel except for visits to the doctor/therapist or hospital.
<p>Section 5 - Sitting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can sit in any chair as long as I like. <input type="checkbox"/> I can only sit in my favorite chair as long as I like. <input type="checkbox"/> Pain prevents me sitting more than 1 hour. <input type="checkbox"/> Pain prevents me from sitting more than ½ hour. <input type="checkbox"/> Pain prevents me from sitting more than 10 mins. <input type="checkbox"/> Pain prevents me from sitting at all. 	<p>Section 10 – Employment/Homemaking</p> <ul style="list-style-type: none"> <input type="checkbox"/> My normal homemaking/job activities do not cause pain. <input type="checkbox"/> My normal homemaking/job activities increase my pain, but I can still perform all that is required of me. <input type="checkbox"/> I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming). <input type="checkbox"/> Pain prevents me from doing anything but light duties. <input type="checkbox"/> Pain prevents me from doing even light duties. <input type="checkbox"/> Pain prevents me from performing any job/homemaking chores.

Mental Health Assessment Tools

- **Adverse Childhood Experience Questionnaire (ACE)**
- **Depression**
 - PHQ 4 or 9
- **Generalized Anxiety Disorder 7 Item Scale (GAD 7)**
- **PTSD Questionnaire**
- **ADHD Symptom Checklist**

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **often** ...
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever**...
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____
4. Did you **often** feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____
5. Did you **often** feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____
6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____
7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No If yes enter 1 _____
10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Depression

PHQ-4				
Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? <i>(Use "✓" to indicate your answer)</i>	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

(For office coding: Total Score T_____ = _____ + _____ + _____)

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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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 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	0	1	2	3

add columns + +

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

<p>10. If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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The Generalized Anxiety Disorder 7-Item Scale

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score: = **Add Columns** _____ + _____ + _____

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 at all **Somewhat difficult** **Very difficult** **Extremely Difficult**
 _____ _____ _____ _____

Interpreting the Score:

Total Score	Interpretation
≥10	Possible diagnosis of GAD; confirm by further evaluation
5	Mild Anxiety
10	Moderate anxiety
15	Severe anxiety

PTSD Questionnaire

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (<i>as if you were actually back there reliving it</i>)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (<i>for example, heart pounding, trouble breathing, sweating</i>)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (<i>for example, people, places, conversations, activities, objects, or situations</i>)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (<i>for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous</i>)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (<i>for example, being unable to feel happiness or have loving feelings for people close to you</i>)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist Instructions

The questions on the back page are designed to stimulate dialogue between you and your patients and to help confirm if they may be suffering from the symptoms of attention-deficit/hyperactivity disorder (ADHD).

Description: The Symptom Checklist is an instrument consisting of the eighteen DSM-IV-TR criteria. Six of the eighteen questions were found to be the most predictive of symptoms consistent with ADHD. These six questions are the basis for the ASRS v1.1 Screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining twelve questions.

Instructions:

Symptoms

1. Ask the patient to complete both Part A and Part B of the Symptom Checklist by marking an X in the box that most closely represents the frequency of occurrence of each of the symptoms.
2. Score Part A. If four or more marks appear in the darkly shaded boxes within Part A then the patient has symptoms highly consistent with ADHD in adults and further investigation is warranted.
3. The frequency scores on Part B provide additional cues and can serve as further probes into the patient's symptoms. Pay particular attention to marks appearing in the dark shaded boxes. The frequency-based response is more sensitive with certain questions. No total score or diagnostic likelihood is utilized for the twelve questions. It has been found that the six questions in Part A are the most predictive of the disorder and are best for use as a screening instrument.

Impairments

1. Review the entire Symptom Checklist with your patients and evaluate the level of impairment associated with the symptom.
2. Consider work/school, social and family settings.
3. Symptom frequency is often associated with symptom severity, therefore the Symptom Checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how these problems have affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other.

History

1. Assess the presence of these symptoms or similar symptoms in childhood. Adults who have ADHD need not have been formally diagnosed in childhood. In evaluating a patient's history, look for evidence of early-appearing and long-standing problems with attention or self-control. Some significant symptoms should have been present in childhood, but full symptomology is not necessary.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date					
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.			Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?							
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?							
3. How often do you have problems remembering appointments or obligations?							
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?							
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?							
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?							
Part A							
7. How often do you make careless mistakes when you have to work on a boring or difficult project?							
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?							
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?							
10. How often do you misplace or have difficulty finding things at home or at work?							
11. How often are you distracted by activity or noise around you?							
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?							
13. How often do you feel restless or fidgety?							
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?							
15. How often do you find yourself talking too much when you are in social situations?							
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?							
17. How often do you have difficulty waiting your turn in situations when turn taking is required?							
18. How often do you interrupt others when they are busy?							
Part B							