

Beck Anxiety Inventory & Scoring

Patient's Name _____ Today's Date _____

Age _____ Gender _____ Physician's Name Dr. Guy Yatsushiro

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	- 0 - NOT AT ALL	- 1 - MILDLY It did not bother me much.	- 2 - MODERATELY It was very unpleasant, but I could stand it.	- 3 - SEVERELY I could barely stand it.
Numbness or tingling				
Feeling hot				
Wobbliness in legs				
Unable to relax				
Fear of the worst happening				
Dizzy or lightheaded				
Heart pounding or racing				
Unsteady				
Terrified				
Nervous				
Feelings of choking				
Hands trembling				
Shaky				
Fear of losing control				
Difficulty breathing				
Fear of dying				
Scared				
Indigestion or discomfort in abdomen				
Faint				
Face flushed				
Sweating (not due to heat)				
TOTAL				

MAXIMUM SCORE = 63 POINTS

0-7 = Minimal Anxiety | 8-15 = Mild Anxiety | 16-25 = Moderate Anxiety | 26-63 = Severe Anxiety

TOTAL SCORE

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, TOTAL: _____
please refer to accompanying scoring card).

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 _____

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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THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? <i>Please circle one response only.</i>		
No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

SCORING THE MOOD DISORDER QUESTIONNAIRE (MDQ)

The MDQ was developed by a team of psychiatrists, researchers and consumer advocates to address a critical need for timely and accurate diagnosis of bipolar disorder, which can be fatal if left untreated. The questionnaire takes about five minutes to complete, and can provide important insights into diagnosis and treatment. Clinical trials have indicated that the MDQ has a high rate of accuracy; it is able to identify seven out of ten people who have bipolar disorder and screen out nine out of ten people who do not.¹

A recent National DMDA survey revealed that nearly 70% of people with bipolar disorder had received at least one misdiagnosis and many had waited more than 10 years from the onset of their symptoms before receiving a correct diagnosis. National DMDA hopes that the MDQ will shorten this delay and help more people to get the treatment they need, when they need it.

The MDQ screens for Bipolar Spectrum Disorder, (which includes Bipolar I, Bipolar II and Bipolar NOS).

If the patient answers:

1. **“Yes”** to seven or more of the 13 items in question number 1;

AND

2. **“Yes”** to question number 2;

AND

3. **“Moderate”** or **“Serious”** to question number 3;

you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

ACKNOWLEDGEMENT: This instrument was developed by a committee composed of the following individuals: Chairman, Robert M.A. Hirschfeld, MD – University of Texas Medical Branch; Joseph R. Calabrese, MD – Case Western Reserve School of Medicine; Laurie Flynn – National Alliance for the Mentally Ill; Paul E. Keck, Jr., MD – University of Cincinnati College of Medicine; Lydia Lewis – National Depressive and Manic-Depressive Association; Robert M. Post, MD – National Institute of Mental Health; Gary S. Sachs, MD – Harvard University School of Medicine; Robert L. Spitzer, MD – Columbia University; Janet Williams, DSW – Columbia University and John M. Zajecka, MD – Rush Presbyterian-St. Luke’s Medical Center.

¹ Hirschfeld, Robert M.A., M.D., Janet B.W. Williams, D.S.W., Robert L. Spitzer, M.D., Joseph R. Calabrese, M.D., Laurie Flynn, Paul E. Keck, Jr., M.D., Lydia Lewis, Susan L. McElroy, M.D., Robert M. Post, M.D., Daniel J. Rapport, M.D., James M. Russell, M.D., Gary S. Sachs, M.D., John Zajecka, M.D., “Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire.” *American Journal of Psychiatry* 157:11 (November 2000) 1873-1875.

Fall Risk Assessment Questionnaire

Please mark "yes" or "no" for each statement below.

Yes	No	
-1	0	
		I have fallen in the last 6 months.
		I use or have been advised to use a cane or walker to get around safely.
		Sometimes I feel unsteady when I am walking.
		I steady myself by holding onto furniture when I walk.
		I am worried about falling.
		I need to push with my hands to stand up from a chair.
		I am often dizzy when I first stand up.
		I have trouble stepping up onto a curb.
		I often have to rush to the toilet.
		I have lost some feeling or have pain in my feet.
		I take medicine that sometimes makes me feel light-headed or more tired than usual.
		I take medicine to help me sleep or improve my mood.
		I often feel sad or depressed.
Total		4 indicates potential fall risk

Nutrition Assessment Form

Please check if you are currently taking any of the following:

- ☐ Multi-vitamins: brand: _____
- ☐ Single Vitamins (Vitamin C, E, etc): type(s): _____
- ☐ Calcium: type: _____ Amount: _____
- ☐ Herbs: type(s): _____
- ☐ Other: _____
- ☐ Food Allergies/ Intolerances: _____

Please check (ü) everything below that describes your eating pattern and/or lifestyle behaviors:

	1. I eat large portions, get seconds or overfill my plate		11. I don't take time to plan healthy meals ahead
	2. I skip meals or go for longer than 5 hours between meals		12. I am tempted by family/friends to eat unhealthy foods
	3. I dine out (includes carry-out) more than 3 times a week		13. I lack the knowledge to cook healthy
	4. I frequently eat fried foods, fast foods and high fat foods		14. I never feel "full" or satisfied after eating
	5. I frequently eat sweets and desserts (candy, cakes, cookies)		15. When dieting, I go to extremes
	6. I graze (snack on food all day long while doing other things (reading, watching TV, computer work)		16. I drink less than 64 ounces (8 cups) daily (all fluids count)
	7. I eat too quickly		17. I usually drink two or more alcoholic beverages daily
	8. I am an emotional eater (I eat when I am stressed, bored, anxious...)		18. My work schedule hinders my weight loss efforts
	9. I am so busy; I forget to stop and eat		19. I would have a difficult time reducing or giving up: _____
	10. I am a "picky" eater		Other: _____

Goals & Readiness Assessment

I want to lose weight because:

My nutrition-related goals are:

If I could change 3 things about my health & nutritional habits, they would be:

The biggest challenge(s) to reaching my nutrition/weight loss goals are:

Epworth Sleepiness Scale

Patient's Name _____ Today's Date _____

Age _____ Gender _____ Physician's Name Dr. Guy Yatsushiro

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you. Place an X in the corresponding space for each situation.

	- 0 - WOULD NEVER DOZE	- 1 - SLIGHT CHANCE OF DOZING	- 2 - MODERATE CHANCE OF DOZING	- 3 - HIGH CHANCE OF DOZING
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. a theatre or a meeting)				
A passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				
TOTAL				

SCORING: 0-12 = Normal | 10-12 = Borderline | 12-24 = Abnormal

TOTAL SCORE

Female Sexual Function Screener

Patient's Name _____ Today's Date _____

Age _____ Gender _____ Physician's Name Dr. Guy Yatsushiro

These questions ask about your present experience. Circle the response that best describes your own situation. Please be sure that you select only one response for each question.

A. Are you satisfied with your level of sexual desire or interest?

- 0. Always
- 1. Most Times
- 2. Sometimes
- 3. Never

B. Are you satisfied with your level of lubrication during sexual activity or intercourse?

- 0. Always
- 1. Most Times
- 2. Sometimes
- 3. Never

C. Are you satisfied with your overall sexual life?

- 0. Satisfied
- 1. Neutral
- 2. Dissatisfied

D. Do you experience discomfort or pain during sexual activity or intercourse?

- 0. No
- 1. Yes

SCORING: 0-3 = No action | 4-10 = Assess further

TOTAL SCORE