THIS FORM HAS 2 SIDES. COMPLETE BOTH SIDES AND RETURN TO YOUR PROVIDER.

PHQ-9 & GAD-7

Today's Date: ________________ Date of birth: _____/_______/______

First Name: __________________________________ Last Name: ______________________________________

PHQ-9-Patient Health Questionnaire

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?	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 over eating	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 the score for each column		+	+	

Total Score (add your column scores)	

If you checked off any problems, how difficult have these 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______

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PHQ-9 & GAD-7

GAD-7
Generalized Anxiety Disorder 7-item scale

Over the last 2 weeks, on how many days have you been bothered by any of 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's 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
Add the score for each column		+	+	

Total Score (add your column scores)	

If you checked off any problems, how difficult have these 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________

Source: Sptizer, RL, Kroenke K, Williams JBW, Loew B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006; 166:1092-1097

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A@663B 10-04-2005

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NYSTROM & ASSOCIATES

PSYCHIATRIC MEDICATION TRANSFER OF CARE EVALUATION PACKET

Today's Date: _______________

Identification:

Name:____Date of Birth:_____________________

Nickname/Preferred Name:__________________________________Preferred Pronouns:__________

Preferred Pharmacy: ____

Emergency Contact/Relationship:__________________________________Phone: ___________________

Current Providers:

If anything below applies to the patient, it is requested that a release of information be placed on file.

Legal Guardian: appointed person for making medical decisions: ____

Phone: _________________________________Cell/Pager_______________________________

Medical/Primary Care Provider: ____

Clinic: ____

Phone:________________________ Date of last physical: ____________________

Home Health Nurse or PCA: ____

Company:____ Phone: ________________________

Psychologist/Therapist: ____

Clinic:____ Phone: ________________________

County Social Worker/Case Manager: ____

Phone:___________________________ Cell/Pager: _____________________________

Probation Officer: ____

Phone:___________________________ Cell/Pager: _____________________________

ARMHS Worker: ____

Phone:___________________________ Cell/Pager: _____________________________

Support Person or Persons:

Name_______________________ Phone:_______________________ Cell/Pager: ______________________

Name_______________________ Phone:_______________________ Cell/Pager: ______________________

What questions or concerns do you have for your provider today? What symptoms are you currently experiencing? What is your expectation for today's appointment?

What medications are you currently taking, including vitamins and herbal supplements?

Have you been hospitalized for any reason since you last saw a Psychiatric Medication Provider?

- ☐ No
- ☐ Yes

If yes, what was the reason for the hospitalization? ____
When and where were you hospitalized? ____

Have you been in any other mental health or substance use treatment since you last saw a Psychiatric Medication Provider?

- ☐ No
- ☐ Yes

If yes, for what service, when and where? ____

____

TURN PAGE OVER

Have there been any other changes in your life since you last saw a Psychiatric Medication Provider? (ex. Marriage, divorce, job changes, change of address, legal issues)

Additional Comments: