Mid Cities Psychiatry

Patient Health Questionnaire (PHQ-9)

Please select each appropriate answer in the question as to over the last 2 weeks, how often have you been bothered by any of the following problems?
Use the following scale to choose the most appropriate number for each situation….

#s	Questions	frequency			
		Not At All	Several Days	More Than Half of 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 in some way	0	1	2	3
	Add Columns…….				
	Your PHQ-9 Scale Total Score Is….				

If you checked off any of the 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	

Mid Cities Psychiatry provides Transcranial Magnetic Stimulation aka TMS Therapy.
TMS Therapy is an alternative treatment for patients suffering from depression for whom medication has proven ineffective. and provides new hope for people who want to reduce or possibly eliminate the use of prescription medications to treat their depression.
Patient agrees to be contacted by a patient advocate to know more about TMS Therapy….

Yes _____ No _____

Name of Patient _____ Date of Birth _____

Signature of Patient or Responsible Party (if minor Patient) _____ Date _____

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Seema Kazi, MD

Mid Cities Psychiatry

Generalized Anxiety Disorder Questionnaire (GAD-7)

Please select each appropriate answer in the question as to over the last 2 weeks, how often have you been bothered by any of the following problems?
Use the following scale to choose the most appropriate number for each situation….

#s	Questions	frequency			
		Not At All	Several Days	More Than Half of 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
	Add Columns…….				
	Your GAD Scale Total Score Is….				

If you checked off any of the 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

Anxiety level based on score is;	no Anxiety (0-4)	mild (5-9)	moderate (10-14)	severe (15-21)

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Alcohol Screening Questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 Times a Month	2-3 Times a Week	4 or more Times a Week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M	0-4	5-14	15-19	20+
W	0-3	4-12	13-19	20+

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