

PATIENT FORM
Memory and Brain Wellness Clinic
PHQ-9, GAD-7 & Patient Concerns

Important: This form is to be filled out by the **PATIENT**. Please fill out both front and back. If the patient is unable to fill out this form, please leave it blank.

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?		Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1	Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 (0) <input type="checkbox"/>	Somewhat difficult (1) <input type="checkbox"/>	Very difficult (2) <input type="checkbox"/>	Extremely difficult (3) <input type="checkbox"/>
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PROVIDER SIGNATURE	PRINT NAME	PAGER	NPI	TIME	DATE
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PLACE PATIENT LABEL HERE

UW Medicine
 Harborview Medical Center – University of Washington Medical Center
 UW Neighborhood Clinics – Valley Medical Center
 University of Washington Physicians Seattle, Washington

M&BW PATIENT QUESTIONNAIRE

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WHITE - MEDICAL RECORD

