Adult Follow-Up*

*Adapted from the PHQ-9 and GAD-7

Full Name (Last, First): _____ **Date of Birth** :_____

Today's Date: _____

Instructions: Over the last 7 days, how often have you been bothered by any of the following problems?
(Click a box to choose answer for each question)

		Not at all	Several days	More than half the days	Nearly every day	*Office Use*
1.	Little interest or pleasure in doing things	☐	☐	☐	☐	
2.	Feeling down, depressed, or hopeless	☐	☐	☐	☐	
3.	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐	
4.	Feeling tired or having little energy	☐	☐	☐	☐	
5.	Poor appetite or overeating	☐	☐	☐	☐	
6.	Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐	
7.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐	
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	☐	☐	☐	☐	
9.	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐	
				Office use: Total/Partial Raw Score:		
10.	Feeling nervous, anxious or on edge	☐	☐	☐	☐	
11.	Not being able to stop or control worrying	☐	☐	☐	☐	
12.	Worrying too much about different things	☐	☐	☐	☐	
13.	Trouble relaxing	☐	☐	☐	☐	
14.	Being so restless that it is hard to sit still	☐	☐	☐	☐	
15.	Becoming easily annoyed or irritable	☐	☐	☐	☐	
16.	Feeling afraid as if something awful might happen	☐	☐	☐	☐	
				Office use: Total/Partial Raw Score:		
17.	**In the last month**, how often did you drink 4 or more drinks on a single occasion? _____					
18.	Have there been any changes in use of nicotine products, alcohol, other drug use? ☐ Yes ☐ No					
19.	Have there been any positive changes or emergence of any new stressors in your life since our last visit? ☐ Yes ☐ No **If yes,** please describe: _____					
20.	Any new physical health concerns, symptoms or diagnosis? ☐ Yes ☐ No **If yes,** please describe: _____					
21.	Any new over the counter, prescription medications or supplements since your last visit? ☐ Yes ☐ No **If yes,** please describe: _____					
22.	What would you like to focus on in today's visit? _____					