Mood Disorder Questionnaire

Patient name: ______________________________ Date of visit: _______________

Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and..	YES	NO
..you felt so good or 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 that you didn't really miss it?		
..you were 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 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 in trouble?		
2. If you checked YES to more than one of the above, have several of these 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?

___None ___Minor ___Moderate ___Serious

Depression Self- Rating Test

Name:________________________ Date:______________

Please complete the following questionnaire and return it to your healthcare provider. Circle the one response to each item that best describes you for the past seven days.

1. Falling asleep:
   0 I never take longer than 30 minutes to fall asleep.
   1 I take at least 30 minutes to fall asleep, less than half the time.
   2 I take at least 30 minutes to fall asleep, more than half the time
   3 I take more than 60 minutes to fall asleep, more than half the time

2. Sleep during the night:
   0 I do not wake up at night
   1 I have a restless, light sleep with a few brief awakenings each night
   2 I wake up at least once a night, but I go back to sleep easily.
   3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time

3. Waking up too early:
   0 Most of the time, I awake no more than 30 minutes before I need to get up
   1 More than half the time, I awaken more than 30 minutes before I need to get up
   2 I am almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
   3 I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping too much:
   0 I sleep no longer than 7-8 hours/ night, without napping during the day.
   1 I sleep no longer than 10 hours in a 24- hour period, including naps.
   2 I sleep no longer than 12 hours in a 24-hour period, including naps.
   3 I sleep longer than 12 hours in a 24-hour period, including naps

5. Feeling sad:
   0 I do not feel sad
   1 I feel sad less than half the time
   2 I feel sad more than half the time
   3 I feel sad nearly all the time

6. Decreased Appetite:
   0 There is no change in my usual appetite
   1 I eat somewhat less often or lesser amounts of food than usual.
   2 I eat much less than usual and only with personal effort
   3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

7. Increased Appetite:
   0 There is no change in my usual appetite
   1 I feel I need to eat more frequently
   2 I regularly eat more frequently/ greater amounts
   3 I feel driven to overeat both at meal time and between meals

8. Decreased weight (within last 2 weeks):
   0 I have not had any change in my weight
   1 I feel as if I've had a slight weight loss
   2 I have lost 2 pounds or more
   3 I have lost 5 pounds or more

9. Increased weight (within last 2 weeks):
   0 I have not had a change in my weight.
   1 I feel as if I've had a slight weight gain
   2 I have gained 2 pounds or more
   3 I have gained 5 pounds or more

10. Concentration/Decision making:
   0 There is no change in my usual capacity to concentrate or make decisions.
   1 I occasionally feel indecisive or find that my attention wanders.
   2 Most of the time, I struggle to focus my attention or to make decisions.
   3 I cannot concentrate well enough to read or cannot make even minor decisions.

11. View of myself:
   0 I see myself as equally worthwhile and deserving as other people.
   1 I am more self-blaming than usual.
   2 I largely believe that I cause more problems for others.
   3 I think almost constantly about major and minor decisions.

12. Thoughts of death or suicide:
   0 I do not think of suicide or death
   1 I feel that life is empty or wonder if it's worth living,
   2 I think of suicide or death several times a week for several minutes.
   3 I think of suicide or death several times a day in some detail, or have made specific plans for suicide or have actually tried to take my life.

13. General interest:
   0 There is no change from usual in how interested I am in other people or activities.
   1 I notice that I am less interested in people or activities.
   2 I find I have interest in only one or two of my formerly pursued activities.
   3 I have almost no interest in things.

14. Energy level:
   0 There is no change in my usual level of energy.
   1 I get tired more easily than usual.
   2 I must make a big effort to start or finish my formerly pursued activities.
   3 I really cannot carry-out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down.
   0 I think, speak, and move at my usual rate of speed.
   1 I find that my thinking is slowed down or my voice sounds dull or flat.
   2 It takes me several seconds to respond to most questions, and I'm sure my thinking is slowed.
   3 I am often unable to respond to questions without extreme effort.

16. Feeling restless:
   0 I do not feel restless
   1 I am often fidgety, wringing my hands, or need to shift how I am sitting.
   2 I have impulses to move about and am quite restless.
   3 At times, I am unable to stay seated and need to pace around.

FOR PROVIDER:

To score:
Enter the highest score on any 1 of the items

Sleep items (1-4):	_____
Item 5 :	_____
Appetite/Weight items (6-9):	_____
Item 10:	_____
Item 11:	_____
Item 12:	_____
Item 13:	_____
Item 14:	_____
Psychomotor items(15&16):	_____
Total score (range 0-27)	_____

Scoring criteria: Normal 0-5 Mild 6-10
Severe 16-20 Very severe 21+

MINI Patient Health Survey

Patient Name:____________________ Date:_____________

Section I Male _____ Female _____ Age ______ Phone: _________________

Yes	No	
		1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?
		2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?

If your answer to both questions above is 'no,' please go to section II without answering question 3 below

Yes	No	3. Over the past two weeks, when you felt depressed or uninterested:
		a. Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e. by plus or minus 5% body weight or plus or minus 8 lbs or plus or minus 3.5 kg for a 160 lb/70 kg person in a month)? (If yes to either, please check 'yes'.)
		b. Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?
		c. Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?
		d. Did you feel tired or without energy almost every day?
		e. Did you feel worthless or guilty almost every day?
		f. Did you have difficulty concentrating or making decisions almost every day?
		g. Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead?

Section II

Yes	No	
		1. In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?

If your answer to this question is 'no', you have completed section II- please do not answer the questions below. Go to section III

		2. In the past 12 months:
		a. Did you need to drink more in order to get the same effect as when you first started drinking?
		b. When you cut down on drinking did your hands shake, did you sweat and feel agitated? Did you drink to avoid these symptoms? (If yes to either, please check 'yes'.)

		c. During the times when you drank alcohol, did you end up drinking more than you planned when you started?
		d. Have you tried to reduce or stop drinking alcohol but failed?
		e. On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovery from the effects of alcohol?
		f. Did you spend less time working, enjoying hobbies, or being with others because of your drinking?
		g. Have you continued to drink even though you knew that it caused you problems?

Section III

Yes	No	
		1. Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? (If yes to either, please check 'yes'.)
		2. At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?

If your answer to both questions above is 'no', please proceed to section IV without answering any other questions below section III.

		3. Have you ever had one such attack, followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack?
		4. During the worst spell that you can remember:
		a. Did you have skipping, racing or pounding of your head?
		b. Did you have sweaty or clammy hands?
		c. Were you trembling or shaking?
		d. Did you have shortness of breath or difficulty breathing?
		e. Did you have a choking sensation or lump in your throat?
		f. Did you have chest pain, pressure, or discomfort?
		g. Did you have nausea, stomach problems, or sudden diarrhea?
		h. Did you feel dizzy, unsteady, lightheaded, or faint?
		i. Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?
		j. Did you fear that you were losing control or going crazy?
		k. Did you fear that you were dying?
		l. Did you have tingling or numbness in parts of your body?
		m. Did you have hot flashes or chills?

		5. In the past month, did you have such attacks repeatedly (two or more), followed by persistent fear of having another attack?

Section IV

Yes	No	
		1. In the past month, were you fearful of or embarrassed by being watched or being the focus of attention, or fearful of being humiliated? This included things like speaking in public, eating in public alone or with others, writing while someone watches, or being in social situations.
		2. Is this fear unreasonable?
		3. Do you fear these situations so much that you avoid them or suffer through them?
		4. Does this fear disrupt your normal work or social functioning or cause you significant distress?

Section V

Yes	No	
		1. Have you had excessive anxiety and worry, occurring more days than not for at least six months, about several events or activities (such as work or school performance)?
		2. Did you find it difficult to control the worry?

If you answered 'no' to question 1 or 2 in this section, you are finished. If you answered 'yes' please answer these last two questions.

		3. During that 6 months, which of the following symptoms were present for more days than not?
		a. Restlessness or feeling keyed up or on edge
		b. Being easily fatigued
		c. Difficulty concentrating or mind going blank
		d. irritability
		e. muscle tension
		f. sleep disturbance (difficult falling or staying asleep, restlessness, or unsatisfying sleep)
		4. Does the anxiety, worry, or physical symptoms disrupt your normal work or functioning, or cause you significant distress?

FOR PROVIDER:

DX: OK D AD PD SAD GAD
Other:________________________________

RX by provider only? YES NO

Provider Initials: ______