Patient Name: _____ Date: _____

Patient Date of Birth: _____

The Patient Health Questionnaire (PHQ-9)

As per the **American Academy of Pediatrics** clinical guidelines, depression screenings for anyone 18 or older are now standard of care in pediatric offices. Please answer the questions on the screening questionnaire. Your clinician will review the form during your appointment today.

Over the past 2 weeks, how often 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 asleep, 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're 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
	Column Totals			
	Add Totals Together			

10. If you checked off any problems, how difficult have those 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

*Patient Name:*_____ *DOB:*_____

*Risk Assessment **7 years and older***

TB risk

Was your child born in Africa/Asia/Latin America/Caribbean/Eastern Europe?	YES	NO
Has your child traveled to Africa/Asia/Latin America/Caribbean/Eastern Europe?	YES	NO
Has a family member or contact had tuberculosis or a positive tuberculin skin test?	YES	NO
Is your child infected with HIV?	YES	NO
Has your child spent time with anyone during the past year who has been in jail or a shelter, uses illegal drugs, or has HIV?	YES	NO

Cholesterol

Does your child have a parent or grandparent who had a stroke or heart problem before age 55?	YES	NO
Does your child have a parent with elevated blood cholesterol (240 or higher) or who is taking cholesterol medication?	YES	NO

Anemia

Is your child's diet lacking in iron-rich foods such as meat, eggs, beans, leafy green vegetables, or iron-fortified cereals?	YES	NO
Is your child on a vegetarian or vegan diet?	YES	NO
Has your child ever been treated for anemia?	YES	NO