Patient Name: _____ Date: _____

Patient Date of Birth: _____

## The Patient Health Questionnaire (PHQ-9)

As per the **American Academy of Pediatrics** clinical guidelines, maternal depression screenings through the 4 month well check 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* ***Birth to 9 months***

*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 |

*Lead*

| | | |
|---|---|---|
| Does your child live in or frequently visit a house/building built before 1950? | YES | NO |
| Does your child live in or frequently visit a house/building built before 1978 with recent or ongoing renovations within the last 6 months? | YES | NO |
| Does your child have any siblings/ housemates/playmates that are being treated for lead poisoning? | YES | NO |

*Fluoride*

| | | |
|---|---|---|
| Do you have well water? | YES | NO |
| Does your family use bottled water exclusively? | YES | NO |

*Anemia*

| | | |
|---|---|---|
| Did your baby weigh less than 3.5 pounds at birth? | YES | NO |
| Was your baby born more than one month early? | YES | NO |
| Has your baby consumed whole milk prior to 9 months of age? | YES | NO |
| Has your child ever been treated for anemia? | YES | NO |