NAME: _____

Date: ____/ ____/ _____

Optimae
BEHAVIORAL HEALTH SERVICES

Over the last 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 or 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 are 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 a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or thoughts of hurting yourself in some way	0	1	2	3
Add Columns	0	0 +	0 +	0
	Total	0		
If you checked any of the above 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 at all	Somewhat difficult	Very difficult	Extremely difficult
	0	1	2	3

For Office Use Only	
Dx? **Bipolar** ◯ **MDD** ◯ **Neither** ◯	**Tobacco Use?** **Yes** ◯ **No** ◯
PHQ-9 Score: **<10** ◯ **10+** ◯	**Referred to QuitLine?** **Yes** ◯ **No** ◯