



AMHA-NW PERSONAL HEALTH QUESTIONNAIRE: Long Form v.3

Name			
Date of birth		Date today	

This questionnaire is an important part of providing you will the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability.

A. During the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered 0	Bothered a little 1	Bothered a lot 2		
1. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Pain in your arms, legs, joints (knees, hips, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5. Trouble falling or staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
6. Menstrual cramps or other problems with periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7. Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
9. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
10. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
11. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
12. Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
13. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
14. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
15. Nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PHQ-15 Score	<input type="checkbox"/>	=	<input type="checkbox"/>	+	<input type="checkbox"/>

B. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3			
1. Feeling nervous anxiety or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2. Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3. Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
4. Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
5. Being so restless that it was hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
6. Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
7. Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
GAD-7 Score	<input type="checkbox"/>	=	<input type="checkbox"/>	+	<input type="checkbox"/>	+	<input type="checkbox"/>

C. Questions about anxiety attacks

	No	Yes
a. In the last 4 weeks, have you had an anxiety attack—suddenly feeling fear or panic? If you answered yes:	<input type="checkbox"/>	<input type="checkbox"/>
b. Has this ever happened before?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do some of these attacks come suddenly out of the blue—that is, in situations where you don't expect to be nervous or uncomfortable?	<input type="checkbox"/>	<input type="checkbox"/>
d. Do the attacks bother you a lot or are you worried about having another attack?	<input type="checkbox"/>	<input type="checkbox"/>
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing, pounding, or skipping?	<input type="checkbox"/>	<input type="checkbox"/>

Turn to page 2



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D. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PHQ-9 Score	<input type="checkbox"/>	= <input type="checkbox"/>	+ <input type="checkbox"/>	+ <input type="checkbox"/>

E. Over the last 2 weeks:

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. How many days have you had more than (3 for women, or 4 for men) alcoholic drinks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How often have you used any recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F. If you checked off any problems on this questionnaire, how difficult have the 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. For follow-up visits only:

	Not at all 1	Partly 2	Mostly 3	Very much 4
1. In our last session, we talked about things that are important to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Based on our last session, I felt that my therapist/prescriber understood and respected me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt confident that my therapist/prescriber and I worked well together.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>