NATIONAL NETWORK of DEPRESSION CENTERS

NNDC Mood Outcomes Program

QUESTIONNAIRES

New Participant

Date _________
Participant Initials________

Program Introduction

Welcome to the Mood Outcomes Program! We are using this program to help monitor the progress in treating your mood problems. Our healthcare center is one of over 20 centers participating in this Program as part of a National Network of Depression Centers (or NNDC) initiative to improve treatment for people with mood disorders. Each time you come in for an appointment you will complete four (4) assessment scales prior to seeing your clinician. This should take less than 10 minutes. Your clinician will review your responses with you during your visit to see how your symptoms are changing over time. Tracking your scores on the Mood Outcomes scales is just as important as tracking blood pressure for people with high blood pressure. It will allow us to see how you are doing and make sure we are providing you with the best possible care.

What if I Have Questions?

Please contact the Mood Outcomes Program Coordinator at MoodOutcomesPCC@altarum.org if you have any questions about this Program.

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Visit Date: _______

Site Staff Data Entry Initials ___________
Provider Reviewed Initials:____________

Date _________
Participant Initials________

New Participant Registration Information

1. First Name: ________________

2. Last Name: ________________

3. Email Address: ________________

Note – your email address will only be collected to support login to the Reporting System. It will not be shared with anyone outside the Program.

Demographic Information

1. Date of Birth: (MM/DD/YYYY) ________________

2. Gender: ☐ Male ☐ Female

3. Which of the following best describes your Racial Background??

- ☐ American Indian or Alaska Native
- ☐ Asian/Asian American
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other (please specify) ______________________
- ☐ Unknown

4. Which best describes your Ethnicity?

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

5. What is your Current Relationship Status or Marital Status?

- ☐ Single (Never Married)
- ☐ Married
- ☐ In a committed relationship
- ☐ Separated
- ☐ Widowed
- ☐ Divorced

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Patient Health Questionnaire (PHQ-9)

Instructions: Please circle one number for each statement.

*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 over eating	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 around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
10. If you checked off any 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?	☐	☐	☐	☐

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NNDC Common Baseline Assessment: Self-Rated (April 2, 2018)

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Generalized Anxiety Disorder Scale (GAD-7)

Instructions: Please circle one number for each statement.

*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. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
If you checked off any 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?	☐	☐	☐	☐

Spitzer, R.L., Kroenke, K., Williams, J.B.W., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med, 166, 1092-97.

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C-SSRS: Screening

Please answer questions 1-5 considering **the LAST MONTH**

1. Have you wished that you were dead or wished you could to go sleep and not wake up? ☐ Yes ☐ No

2. Have you actually had any thoughts of killing yourself? ☐ Yes ☐ No

   *If you answered "**Yes**" to #2, please answer the following: (If you have not had any thoughts to kill yourself, skip the next 3 questions)*

   3. Have you been thinking about how you might kill yourself? ☐ Yes ☐ No

   4. Have you had these thoughts and had some intention of acting on them? ☐ Yes ☐ No

   5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? (answer "**Yes**" if the response to either question is true) ☐ Yes ☐ No

6. **Have you ever made a suicide attempt – purposely tried to harm yourself with at least some intention to end your life?** *(For example: swallowed any pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.)* ☐ Yes ☐ No

   If you answered "**Yes**" to #6, how many times **in your life** did this happen? ____________

   If you answered "**Yes**" to #6, did it happen in the **last 3 months**? ☐ Yes ☐ No

7. **Have you taken any steps to prepare to kill yourself** *(For example: collecting pills, getting a gun, giving valuables away, writing a suicide/ goodbye note, etc.)* **or actually started to do something to end your life and stopped or were stopped before you actually did anything?** *(For example: took out pills but didn't swallow any, went up to roof but changed your mind and didn't jump, had gun in your hand but someone grabbed it from you, etc.)* ☐ Yes ☐ No

   If you answered "Yes" to #7, how many times in your life did this happen? ____________

   If you answered "Yes" to #7, did it happen in the last 3 months? ☐ Yes ☐ No

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