NATIONAL NETWORK *of*
DEPRESSION CENTERS

NNDC Mood Outcomes Program

QUESTIONNAIRES

Returning Participants

Date _________
Participant Initials________

Welcome Back to the Mood Outcomes Program!

Participant Information

1. First Name: ________________

2. Last Name: ________________

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

4. 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.

For Internal Office Use Only

Site: _______
Visit Date: _______

Site Staff Data Entry Initials ___________
Provider Reviewed Initials:____________

Date _________
Participant Initials________

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

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?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

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: Follow-up

Please answer these questions **considering the period since your last visit in this clinic**

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. **Since your last visit to this clinic have you 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

7. **Since your last visit to this clinic 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

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