Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	**YES**	**NO**
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name _____ **Today's Date** _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an **X** in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

Part A	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
Part B					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Depression Outcome Scale*

Patient name _____ Date _____

Instructions

This questionnaire includes questions about symptoms of depression. For each item please indicate how well it describes you during the **past week, including today**. Circle the number in the columns next to the item that best describes you.

Rating guidelines†

0 = Not at all
1 = Rarely true (1–2 days)
2 = Sometimes true (3–4 days)
3 = Often true (5–6 days)
4 = Almost always true (every day)

†Please note: This is not a diagnostic tool. Only a healthcare professional can diagnose depression. Always follow the healthcare advice of your doctor. Do not change the way you take your medication without talking to your doctor.

During the PAST WEEK, INCLUDING TODAY...

1.	I felt sad or depressed	**0**	**1**	**2**	**3**	**4**
2.	I was not as interested in my usual activities	**0**	**1**	**2**	**3**	**4**
3.	My appetite was poor and I didn't feel like eating	**0**	**1**	**2**	**3**	**4**
4.	My appetite was much greater than usual	**0**	**1**	**2**	**3**	**4**
5.	I had difficulty sleeping	**0**	**1**	**2**	**3**	**4**
6.	I was sleeping too much	**0**	**1**	**2**	**3**	**4**
7.	I felt very fidgety, making it difficult to sit still	**0**	**1**	**2**	**3**	**4**
8.	I felt physically slowed down, like my body was stuck in mud	**0**	**1**	**2**	**3**	**4**
9.	My energy level was low	**0**	**1**	**2**	**3**	**4**
10.	I felt guilty	**0**	**1**	**2**	**3**	**4**
11.	I thought I was a failure	**0**	**1**	**2**	**3**	**4**
12.	I had problems concentrating	**0**	**1**	**2**	**3**	**4**
13.	I had more difficulties making decisions than usual	**0**	**1**	**2**	**3**	**4**
14.	I wished I was dead	**0**	**1**	**2**	**3**	**4**
15.	I thought about killing myself	**0**	**1**	**2**	**3**	**4**
16.	I thought that the future looked hopeless	**0**	**1**	**2**	**3**	**4**

Overall, how much have symptoms of depression interfered with or caused difficulties in your life during the past week? (Circle one)

a) Not at all b) A little bit c) A moderate amount
d) Quite a bit e) Extremely

*Adapted from the Clinically Useful Depression Outcome Scale (CUDOS), developed by Mark Zimmerman, MD, Director of Outpatient Psychiatry at Rhode Island Hospital. *Compr Psychiatry*. 2008;49(2):131-140.

The Clinically Useful Depression Outcome Scale (CUDOS) is a practice support service provided by Otsuka America Pharmaceutical, Inc.

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**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 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

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐