Mood Disorder Questionnaire (MDQ)

The MDQ can help your therapist determine what type of mood disorder you may be experiencing.

Instructions: Please check one answer for each question.

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 rights or arguments?	☐	☐
You felt much more self-confident than usual?	☐	☐
You got much less sleep than usual and found you didn't really miss it?	☐	☐
You were much more talkative or spoke 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 much 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 intro trouble?	☐	☐

If you checked "yes" to more than one of the above, have several of these ever happened during the same time period? ☐ Yes ☐ No

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 Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem

- Adapted with permission from Robert M. A. Hirschfeld, M.D.

Patient Health Questionnaire 15-Item Somatic Symptom Severity Scale (PHQ-15)

During the *past 4 weeks,* how much have you been bothered by any of the following problems?	Not bothered at all	Bothered a little	Bothered a lot
Stomach pain	☐	☐	☐
Back pain	☐	☐	☐
Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
Menstrual cramps or other problems with your periods [Women only]	☐	☐	☐
Headaches	☐	☐	☐
Chest pain	☐	☐	☐
Dizziness	☐	☐	☐
Fainting spells	☐	☐	☐
Feeling your heart pound or race	☐	☐	☐
Shortness of breath	☐	☐	☐
Pain or problems during sexual intercourse	☐	☐	☐
Constipation, loose bowels, or diarrhea	☐	☐	☐
Nausea, gas, or indigestion	☐	☐	☐
Feeling tired or having low energy	☐	☐	☐
Trouble sleeping	☐	☐	☐

AUDIT Questionnaire

Questions	0	1	2	4	5	Enter Score
1. How Often do you have a drink containing alcohol	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
If score to 1st question is zero, stop screening here						
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
If the total score for Questions 1-3 is 5 points or higher for Men or 4 points or higher for Women, then continue						
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
10. Has a relative, friend, doctor, or other healthcare worker been concerned about your drinking or suggested you cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
				TOTAL SCORE		

Scores of 8 or more for men (up to age 60) or 4 or more for women, adolescents, and men over the age of 60 are considered positive results.

Brief Patient Health Questionnaire (PHQ-Brief)

This questionnaire is an important part of providing you with 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 unless you are requested to skip a question.

1. 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**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. 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	☐	☐	☐	☐
i. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

2. Questions about anxiety	NO	YES
a. In the last 4 weeks have you had an anxiety attack – suddenly feeling fear or panic	☐	☐
If you checked "NO", go to question #3.		
b. Has this ever happened before?	☐	☐
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?	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. If you checked off any problems on this questionnaire so far, 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**

4. In the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered**	**Bothered a little**	**Bothered a lot**
a. Worrying about your health	☐	☐	☐
b. Your weight or how you look	☐	☐	☐
c. Little or no sexual desire or pleasure during sex	☐	☐	☐
d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
e. The stress of taking care of children, parents, or other family members	☐	☐	☐
f. Stress at work outside of the home or at school	☐	☐	☐
g. Financial problems or worries	☐	☐	☐
h. Having no one to turn to when you have a problem	☐	☐	☐
i. Something bad that happened recently	☐	☐	☐
j. Thinking or dreaming about something terrible that happened to you in the past – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

5. In the last year have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? ☐ **NO** ☐ **YES**

6. What is the most stressful thing in your life right now?

7. Are you taking any medicine for anxiety, depression or stress? ☐ **NO** ☐ **YES**

8.

	Periods are unchanged	No periods because pregnant or recently gave birth	Periods have become irregular or changed in frequency, during or amount	No periods for at least a year	Having periods because taking hormone replacement (estrogen) therapy or oral contraception
a. Which best describes your menstrual periods?	☐	☐	☐	☐	☐

	NO (or does not apply)	**YES**
a. During the week before your period starts, do you have a serious problem with your mood – like depression, anxiety, irritability, anger or mood swings?	☐	☐
b. If YES: Do these problems go away by the end of your period?	☐	☐
c. Have you given birth within the last 6 months?	☐	☐
d. Have you had a miscarriage within the last 6 months?	☐	☐
e. Are you having difficulty getting pregnant?	☐	☐

Developed by Drs Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke, and other colleagues, with an educational grant from Pfizer, Inc.