Chart # _____

CENTRAL COAST PSYCHIATRIC CONSULTANTS

1428 PHILLIPS LANE, SUITE 102
SAN LUIS OBISPO, CA 93401

Name_____Birthdate_____Age____Sex____

Address_____

City_____ State _____Zip Code_____

Contact Phone Number _____Please Circle: Home Work Cell

Alternate Number_____Please Circle: Home Work Cell

Social Security Number_____

Employer _____Occupation_____

Marital Status: M S D W Spouse's Name_____

Referring Physician_____

Emergency Contact/Relationship _____Phone_____

***Please Complete if Different than Above**:*

Responsible Party Name/Relationship_____

Responsible Party Address_____

Responsible Party Phone Number_____ Alt. Number_____

PATIENT HEALTH QUESTIONAIRE

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 Everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things such as reading the newspaper or watching TV	0	1	2	3
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
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Add columns: _____+_____+_____

TOTAL _____

Patient/Responsible Party Signature _____Date_____