

**TABLE 2. The Brief Patient Health Questionnaire**

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 everyday
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				
<b>2. Questions about anxiety</b>	<b>No</b>		<b>Yes</b>	
a. In the last 4 weeks, have you had an anxiety attack – suddenly feeling fear or panic?				
<b><i>If you checked "NO", go to question #3.</i></b>				
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?				
<b>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?</b> <input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult				
<b>4. Are you taking any medicine for anxiety, depression or stress?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes				

*FOR OFFICE CODING: Major Depression Syndrome if answers to #1a or b and five or more of #1a-i are at least "More than half the days" (count #1i if present at all). Other Depression Syndrome if #1a or b and two, three, or four of #1a-i are at least "More than half the days" (count #1i if present at all). Panic Syndrome if all of #2a-e are "YES."*

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