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COLUMBIA SUICIDE SEVERITY RATING SCALE

Please answer these questions considering the period of the LAST MONTH.	Past month	
	YES	**NO**
1) Have you wished you were dead or wished you could go to sleep and not wake up?	L	
2) Have you actually had any thoughts of killing yourself?	L	
If YES to question 2, answer questions 3, 4, 5, and 6. **If NO to question 2, go directly to question 6.**		
3) Have you been thinking about how you might do this? E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"	M	
4) Have you had these thoughts and had some intention of acting on them? As opposed to "*I have the thoughts but I definitely will not do anything about them.*"	H	
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?	H	

6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?	**YES**	**NO**
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
If YES: Was this within the past three months?	H	M

L - Low Risk
M - Moderate Risk
H - High Risk

Adapted with permission of the author March 2019

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Completed by (print and sign) ______________________ Date/Time ______________

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PSYCH PATIENT HEALTH QUESTIONNAIRE 9

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 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	0	1	2	3
	add columns	____	+ ____	+ ____
	TOTAL:	____		

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?

Not difficult at all ________

Somewhat difficult ________

Very difficult ________

Extremely difficult ________

Person Completing this form ____________________ Relationship to Patient ____________________

PennState Health

GENERAL ANXIETY DISORDER 7 ITEM (GAD 7)

DATE: ____

Participants Initials: ______________________________

Instructions: Please circle one number for each statement.

*Over the **last two weeks**, how often have you been bothered by 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 that 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 any problems, how difficult have they 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** ☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc.
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Site: ________________________________ Site Staff Data Entry Initials: ________________

Visit Date: ____________________________ Provider Reviewed Initials: ________________

______________________________ ______________________________
Person Completing this form Relationship to Patient

PennState Health
Milton S. Hershey Medical Center

WHODAS DISABILITY SCALE

In the past 30 days, how much difficulty did you have in: (circle the number that best describes your difficulty)

	None	Mild	Moderate	Severe	Extreme/ Cannot Do
1. Standing for long periods such as 30 minutes?	0	1	2	3	4
2. Taking care of your household responsibilities?	0	1	2	3	4
3. Learning a new task, for example, learning how to get to a new place?	0	1	2	3	4
4. How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	0	1	2	3	4
5. How much have you been emotionally affected by your health problems?	0	1	2	3	4
6. Concentrating on doing something for ten minutes?	0	1	2	3	4
7. Walking a long distance such as a kilometer or half mile?	0	1	2	3	4
8. Washing your whole body?	0	1	2	3	4
9. Getting dressed?	0	1	2	3	4
10. Dealing with people you do not know?	0	1	2	3	4
11. Maintaining a friendship?	0	1	2	3	4
12. Your day-to-day work?	0	1	2	3	4

Disability Score=
Sum of above ____________________

Disability Score may inform additional screening and management options and be used to monitor progress

WHODAS DISABILITY SCALE