Kansas Department of Health and Environment

DAISEY

PHQ-A Form

Which Caregiver/Adult Was Involved (Client Name)?

_____

Date of Activity: ____/____/____

Program

- Becoming a Mom
- Family Planning
- Maternal Child Health (MCH/M&I)
- Pregnancy Maintenance (PMI)
- Teen Pregnancy (TPTCM)
- Kansas Connecting Communities

PHQ-A

Instructions: *How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.*

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling down, depressed, irritable, or hopeless?	0	1	2	3
2. Little interest or pleasure in doing things?	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4. Poor appetite, weight loss, or overeating?	0	1	2	3
5. Feeling tired, or having little energy?	0	1	2	3
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things like school work, reading, or watching TV?	0	1	2	3
8. Moving or speaking so slowly that other people have noticed? Or the opposite – being so fidgety or restless that you were 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

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thought about ending your life?

☐ Yes ☐ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐ Yes ☐ No

**If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Severity score: _____

Programs Providing Follow-Up: (select all that apply)

- Becoming a Mom
- Family Planning
- Maternal Child Health (MCH/M&I)
- Pregnancy Maintenance Initiative (PMI) Teen Pregnancy Targeted Case Management(TPTCM)
- Kansas Connecting Communities (KCC)

Was a brief intervention provided?

- Yes
- No

If yes, what brief intervention was provided?

- Reviewed screening results
- Made clinical recommendations
- Provided education community, and/or treatment resources
- Measured patient-motivation and/or readiness to change
- Reinforced self-efficacy
- Other **Specify other intervention:**

_____

Why was a brief intervention not provided?

Was a referral provided?

- Yes
- No

What provider type was client referred to?

- Beacon Health Options
- Substance Use Treatment Provider
- Internal Mental Health Provider
- External Mental Health Provider CMHC
- External Mental Health Provider Private Practice
- MCO/MCO Care Coordinator
- Community-Based Support Group
- Primary Care Provider
- Other

If other, please specify: _____

Why was a referral not provided?

Was the client in crisis?

- Yes
- No

If yes, what action was taken?