

USE AND SCORING OF THE PATIENT QUESTIONNAIRE

Instructions for Part I (front of questionnaire)

The front page of the Patient Questionnaire may be used to conduct the initial patient screening for depression (either self-directed or by provider interview). If a patient responds “YES” to any of the questions on the front of the questionnaire, providers should consider asking the questions on the back of the questionnaire to assist in determining the severity of depression.

Note: If the patient is completing the form self-directed, they are instructed to continue with the back questions if they responded “YES” to any of the questions on the front.

Instructions for Part II (back of questionnaire)

1. On the patient questionnaire, place a check mark in each box in the second column in which a patient scored greater than zero for that section.
2. Count the number of check marks and write that number at the bottom of the form beside the box labeled “A.”
3. Additionally, sum the total of the scores in the last column (the circled numbers) and write that number at the bottom of the form beside the box labeled “B.”
4. Use the **Screening Score** table below to assist in determining the severity of the depression.

NOTE: If question 9 – “Negative Thoughts” is checked OR if a diagnosis of major depression is made, then the patient’s suicide risk requires assessment and documentation. The questions in the **Suicide Risk Screening Questions** table on the back of this page can assist in determining the severity of this risk.

Screening Score:

Column A	Column B	Dx to Consider	Tx to Consider
1-4	0-9	Mild or Minimal Depressive Symptoms	Positive Reassurance
2-4 AND Q1 or 2 is checked	10-14	Moderate Depressive Symptoms	Develop treatment plan; consider psychotherapy and/or possibly medication
5 or more AND Q1 or 2 is checked	15-19	Major Depressive Disorder	Treat with antidepressant medication; may include psychotherapy
5 or more AND Q1 or 2 is checked	20-24	Severe Major Depression	Treat as above and assess risk
5 or more AND Q1 or 2 is checked	25 or more	Very severe clinical depression	Assess and treat as above; patient may require protective measures

Please note, the symptoms assessed are not accounted for by bereavement, general medical conditions, medications, or drug or alcohol abuse. The symptoms must result in significant impairment of social, occupational, or school functioning.

This information was obtained from the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Washington, DC, American Psychiatric Association, 1994.

SUICIDE RISK TOOLS

When using the SUICIDE RISK SCREENING QUESTIONS table below, score each question with 1 for each “YES” answer and a 0 for each “NO” answer. Sum the responses to get a total score for use in the SUICIDE RISK ASSESSMENT table.

SUICIDE RISK SCREENING QUESTIONS

Category	Question	Score yes = 1 no = 0
Ideation	Have you had thoughts of taking your own life?	
Plans	Have you made any plans to take your own life?	
Means	Do you have access to the tools or situation to take your own life, according to your plan?	
Intent	Do you intend to commit suicide? When?	
History	Have you ever tried to take your own life?	
Total		

SUICIDE RISK ASSESSMENT

Score	Suicide Risk Assessment	Tx Considerations
0	Low Risk	Follow up as needed.
1–2	Moderate Risk	Assess suicide risk at each visit. Refer as needed.
3–5	High Risk	Implement protective measures and emergent management.

REPRINT INFORMATION

The materials in the Toolkit are available for free download on our website.

Reprints of the Screening Tool pads and other materials are also available for a limited time. Please visit our website for pricing and ordering information.

www.DepressionSeries.com

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