

IAPT Minimum Data Set Questionnaires

Patient Name (Please Print) **Date**.....

PHQ- 9

Over the <u>last 2 weeks</u> , 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 in some way	0	1	2	3
PHQ9 Total Score					

GAD-7

Over the <u>last 2 weeks</u> , 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	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
GAD7 Total Score					



IAPT Phobia Scales

Choose a number from the scale below to show how much you would avoid each of the situations or objects listed below. Then write the number in the box opposite the situation.

	0	1	2	3	4	5	6	7	8
	Would not avoid it		Slightly avoid it		Definitely avoid it		Markedly avoid it		Always avoid it
1	Social situations due to a fear of being embarrassed or making a fool of myself								
2	Certain situations because of a fear of having a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness)								
3	Certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying).								

IAPT Employment Status Questions

Please indicate which of the following options best describes your current status:

Not Stated	
Employed (Full Time)	
Employed (Part Time)	
Employed (Self)	
Unemployed (Seeking Work)	
Unemployed	
Benefits	
Student (Full Time)	
Student (part Time)	
Homemaker	
Retired	

Are you currently receiving Statutory Sick Pay?

Yes		No	
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Are you suitable for or feel you would benefit from receiving employment support?

Yes		No	
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for anxiety and depression

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Work and Social Adjustment

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

1. **WORK** - if you are retired or choose not to have a job for reasons unrelated to your problem, please tick N/A (not applicable)

0 1 2 3 4 5 6 7 8 N/A

Not at all Slightly Definitely Markedly Very severely, I cannot work

2. **HOME MANAGEMENT** – Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc

0 1 2 3 4 5 6 7 8

Not at all Slightly Definitely Markedly Very severely

3. **SOCIAL LEISURE ACTIVITIES** - With other people, e.g. parties, pubs, outings, entertaining etc.

0 1 2 3 4 5 6 7 8

Not at all Slightly Definitely Markedly Very severely

4. **PRIVATE LEISURE ACTIVITIES** – Done alone, e.g. reading, gardening, sewing, hobbies, walking etc.

0 1 2 3 4 5 6 7 8

Not at all Slightly Definitely Markedly Very severely

5. **FAMILY AND RELATIONSHIPS** – Form and maintain close relationships with others including the people that I live with

0 1 2 3 4 5 6 7 8

Not at all Slightly Definitely Markedly Very severely

Medication:

Are you currently taking **any** medication? We are interested in **all** the medication you take

Please have a list when we call or indicate here what medications you take

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Please circle as appropriate: Not known Prescribed – not taking Prescribed – taking Not prescribed

Have there been any changes in your medication since your last session?



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