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Standardization of health outcomes assessment for depression and anxiety

Recommendations from the ICHOM Depression and Anxiety Working Group

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ICHOM Treatment Monitoring for Depression and Anxiety v1

The following questions will assess your current health status helping your health care provider to monitor the treatment success and to acknowledge potential health risk factors.

PHQ-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 doing thing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Moving or speaking slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Thoughts that you would be better off dead, or hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GAD-7	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	Feeling nervous, anxious, or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Being so restless that it's hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	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
	Did you receive any treatment for depression over the last two weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	medication <input type="checkbox"/> no <input type="checkbox"/> yes psychological treatment <input type="checkbox"/> no <input type="checkbox"/> yes other <input type="checkbox"/> no <input type="checkbox"/> yes				
	Did you experience medication side-effects? <input type="checkbox"/> no <input type="checkbox"/> yes				
	If Yes, please indicate which side-effects you have experienced:				
2	<input type="checkbox"/> Weight gain <input type="checkbox"/> Sexual dysfunction <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Dry mouth <input type="checkbox"/> Drowsiness/sedation <input type="checkbox"/> Cardiovascular side-effects (e.g. palpitations) <input type="checkbox"/> Gastrointestinal side-effects (e.g. diarrhea, nausea, vomiting) <input type="checkbox"/> Other: _____				