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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 Annual Assessment 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.

		Much better	A Little Better	About the same	A little Worse	Much worse
1	Compared with how you were doing one year ago, would you say that now you are ...?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WHODAS 2.0	In the past 30 days, how much difficulty did you have in:	None	Mild	Moderate	Severe	Extreme or cannot do
1	Standing for long periods such as 30 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Taking care of your household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Learning a new task, for example, learning how to get to a new place?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	How much have you been emotionally affected by your health problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Concentrating on doing something for ten minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Walking a long distance such as a kilometer [or equivalent]?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Washing your whole body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Getting dressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Dealing with people you do not know?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Maintaining a friendship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Your day-to-day work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	
MOS-SSS		People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it?				
		None of the time	A little of the time	Some of the time	Most of the time	All of the time
1	Someone to share your most private worries and fears with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Someone to turn to for suggestions about how to deal with a personal problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Someone to do something enjoyable with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Someone to love and make you feel wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been told by a doctor that you have any of the following chronic health conditions?						
<input type="checkbox"/> I have no chronic condition						
<input type="checkbox"/> Heart disease		<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Leg pain when walking		
<input type="checkbox"/> Lung disease		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Kidney disease		
1	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Problems caused by stroke		<input type="checkbox"/> Disease of the nervous system		
<input type="checkbox"/> Cancer (within the last 5 yrs)		<input type="checkbox"/> Anxiety Disorder		<input type="checkbox"/> Depression		
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Substance abuse		<input type="checkbox"/> Somatoform disorder		
<input type="checkbox"/> Personality disorder		<input type="checkbox"/> Chronic pain disorder		<input type="checkbox"/> Schizophrenic disorder		
Health status and prior treatment						
Did you experience any episodes of depression/anxiety within the last year?						
1	<input type="checkbox"/> I experienced no episodes					
	<input type="checkbox"/> I had one episode					
	<input type="checkbox"/> I had several episodes					
	<input type="checkbox"/> My symptoms of depression do not occur in episodes					
2	During the last year, did you receive any of the following treatments for depression/anxiety?					
	medication	<input type="checkbox"/> no	<input type="checkbox"/> 1-3 months	<input type="checkbox"/> 3-6 months	<input type="checkbox"/> more than 6 months	
3	psychological treatment	<input type="checkbox"/> no	<input type="checkbox"/> 1-3 months	<input type="checkbox"/> 3-6 months	<input type="checkbox"/> more than 6 months	
4	other	<input type="checkbox"/> no	<input type="checkbox"/> 1-3 months	<input type="checkbox"/> 3-6 months	<input type="checkbox"/> more than 6 months	

- 5 Has the treatment of your depression/anxiety over the last year been successful?  
 very much     moderately     somewhat     not at all
- 6 If you took any medication for depression/anxiety, did you take your medication as prescribed?  
 ne                       mostly                       yes
- Did you experience medication side-effects?                       yes                       no
- If Yes, please indicate which side-effects you have experienced:
- 7  Weight gain                       Sexual dysfunction                       Sleep disturbances  
 Dry mouth                       Drowsiness/sedation                       Cardiovascular side-effects (e.g. palpitations)  
 Gastrointestinal side-effects (e.g. diarrhea, nausea, vomiting)     Other: \_\_\_\_\_
- How successful do you think your current therapy will be in reducing your symptoms?
- 8  Not at all successful                       Somewhat successful  
 Moderately successful                       Very successful

Demographic factors

- 1 Which statement best describes your living arrangements?  
 with partner/spouse/family/friends                       alone  
 nursing home/hospital/long term care home     other
- What is your work status?
- 2  Unable to work (due to a condition other than depression or anxiety)     Unable to work (due to depression or anxiety)  
 Not working by choice (student, retired, homemaker)                       Working part-time  
 Seeking employment (I consider myself able to work but cannot find a job)     Working full-time
- 3 How many working days have you missed within the last month due to illness? \_\_\_\_\_ (# of days)