HAMILTON ANXIETY RATING SCALE (HAM-A)

Instructions for the Clinician:

The Hamilton Anxiety Rating Scale (HAM-A) is a widely used and well-validated tool for measuring the severity of a patient's anxiety. It should be administered by an experienced clinician.

The HAM-A probes 14 parameters and takes 15-20 minutes to complete the interview and score the results. Each item is scored on a 5-point scale, ranging from 0=not present to 4=severe.

The major value of HAM-A is to assess the patient's response to a course of treatment, rather than as a diagnostic or screening tool. By administering the scale serially, a clinician can document the results of drug treatment or psychotherapy.

Developed in 1959 by Dr. M. Hamilton, the scale has proven useful not only in following individual patients but also in research involving many patients.

HAM-A Scoring Instructions:

Sum the scores from all 14 parameters.

14-17 = Mild Anxiety

18-24 = Moderate Anxiety

25-30 = Severe Anxiety

Hamilton, M. The assessment of anxiety states by rating. *British Journal of Medical Psychology* 32:50-55, 1959.

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HAMILTON ANXIETY SCALE (HAM-A)

Patient Name _____ **Today's Date** _____

The Hamilton Anxiety Scale (HAM-A) is a rating scale developed to quantify the severity of anxiety symptomatology, often used in psychotropic drug evaluation. It consists of 14 items, each defined by a series of symptoms. Each item is rated on a 5-point scale, ranging from 0 (not present) to 4 (severe).

0 = Not present to 4 = Severe

Score

☐ 1. ANXIOUS MOOD
- Worries
- Anticipates worst

☐ 2. TENSION
- Startles
- Cries easily
- Restless
- Trembling

☐ 3. FEARS
- Fear of the dark
- Fear of strangers
- Fear of being alone
- Fear of animal

☐ 4. INSOMNIA
- Difficulty falling asleep or staying asleep
- Difficulty with Nightmares

☐ 5. INTELLECTUAL
- Poor concentration
- Memory Impairment

☐ 6. DEPRESSED MOOD
- Decreased interest in activities
- Anhedoni
- Insomnia

☐ 7. SOMATIC COMPLAINTS: MUSCULAR
- Muscle aches or pains
- Bruxism

☐ 8. SOMATIC COMPLAINTS: SENSORY
- Tinnitus
- Blurred vision

☐ 9. CARDIOVASCULAR SYMPTOMS
- Tachycardia
- Palpitations
- Chest Pain
- Sensation of feeling faint

☐ 10. RESPIRATORY SYMPTOMS
- Chest pressure
- Choking sensation
- Shortness of Breath

☐ 11. GASTROINTESTINAL SYMPTOMS
- Dysphagia
- Nausea or Vomiting
- Constipation
- Weight loss
- Abdominal fullness

☐ 12. GENITOURINARY SYMPTOMS
- Urinary frequency or urgency
- Dysmenorrhea
- Impotence

☐ 13. AUTONOMIC SYMPTOMS
- Dry Mouth
- Flushing
- Pallor
- Sweating

☐ 14. BEHAVIOR AT INTERVIEW
- Fidgets
- Tremor
- Paces

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**				

10. 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** _____

Fold back this page before administering this questionnaire

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. ***Consider Major Depressive Disorder***
   —if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

   Consider Other Depressive Disorder
   —if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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Geriatric Depression Scale –Short Form

Patient Name: _____ Date: _____

Nurse's Name: _____

Choose the best answer for how you felt this past week:

1. **Are you basically satisfied with your life?** ..... Yes / **No**
2. **Have you dropped many of your activities and interests?** ..... **Yes** / No
3. **Do you feel that your life is empty?** ..... **Yes** / No
4. **Do you often get bored?** ..... **Yes** / No
5. **Are you in good spirits most of the time?** ..... Yes / **No**
6. **Are you afraid that something bad is going to happen to you?** ..... **Yes** / No
7. **Do you feel happy most of the time?** ..... Yes / **No**
8. **Do you often feel helpless?** ..... **Yes** / No
9. **Do you prefer to stay at home, rather than going out and doing new things?** ..... **Yes** / No
10. **Do you feel you have more problems with memory than most?** ..... **Yes** / No
11. **Do you think it is wonderful to be alive now?** ..... Yes / **No**
12. **Do you feel pretty worthless the way you are now?** ..... **Yes** / No
13. **Do you feel full of energy?** ..... Yes / **No**
14. **Do you feel that your situation is hopeless?** ..... **Yes** / No
15. **Do you think that most people are better off than you are?** ..... **Yes** / No

Scoring Key:	Score: _____ (number of depressed" answers –all bolded answers)
Normal	0-4
Mildly depressed	>5 points suggestive of depression
Severely depressed	≥ 10 points is almost always indicative of depression

A score of >5 points should warrant a follow-up comprehensive assessment.

MINI – COG

The Mini-Cog Assessment Instrument for Dementia combines an un-cued 3-item recall test with a clock-drawing test (CDT). The Mini-Cog can be administered in about 3 minutes, requires no special equipment, and is relatively uninfluenced by level of education or language variations.

Administration

The test is administered as follows:

1. Instruct the patient to listen carefully to and remember the following three unrelated words:

   Apple

   Table

   Penny

2. Then ask the patient to repeat the words.

3. Instruct the patient to draw the face of a clock, either on a blank sheet of paper, or on a sheet with the clock circle already drawn on the page. Ask the patient to put the numbers on the clock face

4. After the patient puts the numbers on the clock face, ask him or her to draw the hands of the clock to read a specific time, such as 11:20. These instructions can be repeated, but no additional instructions should be given. Give the patient as much time as needed to complete the task. The CDT serves as the recall distracter.

5. Ask the patient to repeat the 3 previously presented words.

Scoring

Give 1 point for each recalled word after the CDT distracter. Score 1–3.

A score of O indicates positive screen for dementia.

A score of 1 or 2 with an abnormal CDT indicates positive screen for dementia.

A score of 1 or 2 with a normal CDT indicates negative screen for dementia.

A score of 3 indicates negative screen for dementia.

The CDT is considered normal if all numbers are present in the correct sequence and position, and the hands readably display the requested time.

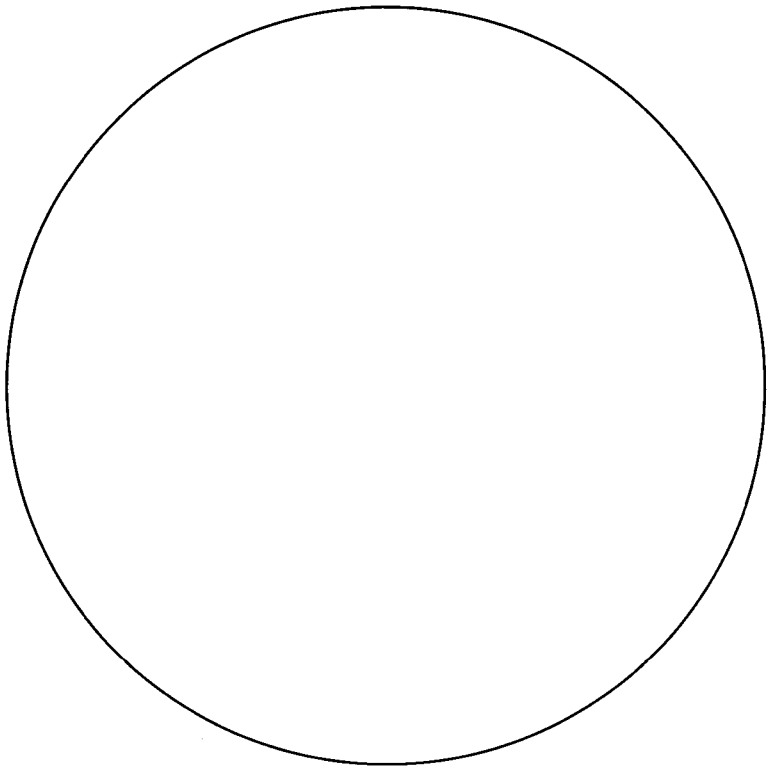
Source: Borson S, Scanlan J, Brush M, Vitaliano P, Dokmak A. The mini-cog: a cognitive "vital signs" measure for dementia screening in multi-lingual elderly. Int J Geriatr Psychiatry 2000; 15(11): 1021–1027.

The Clock Drawing Test in: Palmer RM, Meldon SW. Acute Care. In: Principles of Geriatric Medicine and Gerontology, 5th edition, 2003. Eds. Hazzard, WR et al. McGraw-Hill Pub. pp 157-168. Inouye SK. Delirium in hospitalized older patients. Clin Geriatr Med 1998; 14:745-764

CLOCK DRAWING TASK

Sometimes a referral source will be interested in only the clock drawing task, directions for another version of the Clock Drawing Task used without the recall of the three words appears below.

1. Pre-draw a circle of 3 3/8ths inches in diameter
2. Ask patient to draw number to make the circle look like the face of a clock
3. Divide the clock into four quadrants- one line through the center of the circle and number corresponding to "12"
4. Draw a second line perpendicular to and bisecting the first line
5. Count the number of digits in each quadrant in the clockwise direction beginning with the digit corresponding to "12". If a digit falls on the reference line it is included in the quadrant that is clockwise to the line
6. Any three digits in a quadrant are considered correct
7. For any error in the number of digits in the first, second, or third quadrants, assign a score of 1. For any error in the number of digits in the fourth quadrant assign a number four.
8. Normal range of score is 0-3; abnormal score is 4-7.



CLOCK DRAWING TASK