

## Patient Health Questionnaire-15: Physical Symptoms

During the last 4 weeks, how much have you have been bothered by any of the following problems? Please place a check mark in the box to indicate your answer.

	Not bothered 0	Bothered a little 1	Bothered a lot 2
1. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pain in your arms, legs, or joints (knees, hips, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Menstrual cramps or other problems with your periods [women only]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Feeling tired or having low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL SCORE =