UNIVERSITY OF ALBERTA

REB ID Pro00093776

MAP-AP Participant Questionnaire

Participant ID #: _____

Current date (DD/MM/YY): _____/_____/____

Please complete this questionnaire before your scheduled interview with your pharmacist

(PHQ9)

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 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

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

(GAD 7)

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

(For office coding: Total Score T____ = ____ + ____ + ____ **)**

Side Effects:
Please select any of the following you have experienced since your last questionnaire (if this is your first time filling this questionnaire, do not complete this section)

Nausea	Increased appetite	Weight gain	Altered sex drive
Fatigue	Drowsiness	Trouble Sleeping	Dry Mouth
Blurred vision	Constipation	Thoughts of suicide	Other

If you circled “Thoughts of suicide”, did you act on this? YES or NO

If you circled “Other”, what did you experience?

NOTE: maybe display as a checklist YES or NO

If you have any questions/concerns please contact primary investigator Dr. Yazid Al Hamarneh (780) 492-9608, or Dr. Matt Chow (587) 999-0778