PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date·\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

Mark the box most accurate for you.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Several Days | More than half the days | Nearly every day |
| 1. Little interest or pleasure in doing things |  |  |  |  |
| 1. Feeling down, depressed or hopeless |  |  |  |  |
| 1. Trouble falling or staying asleep or sleeping too much |  |  |  |  |
| 1. Feeling tired or having little energy |  |  |  |  |
| 1. Poor appetite or overeating |  |  |  |  |
| 1. Feeling bad about yourself – or that you are a failure or have let yourself or your family down |  |  |  |  |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television |  |  |  |  |
| 1. 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 |  |  |  |  |
| 1. Thoughts that you would be better off dead or of hurting yourself |  |  |  |  |

TOTAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you checked off any problems, how difficult have Not difficult at all \_\_\_\_\_\_\_\_

these problems made it for you to do your work, take

care of things at home, or get along with other people? Somewhat difficult \_\_\_\_\_\_\_\_

Very difficult \_\_\_\_\_\_\_\_

Extremely difficult \_\_\_\_\_\_\_\_

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