Patient Health Questionnaire (PHQ9)

NAME: ________________________________ DATE: _____________
DATE OF BIRTH: _______________________

Over the last two weeks, how often have you been bothered by any of the following problems? Please circle your response.

	Not at All	Several Days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
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**
Thoughts that you would be better off dead or thoughts of hurting yourself	**0**	**1**	**2**	**3**

Add Columns: ______ + ______+ _______
Total: _________

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 ________