

## Patient Health Questionnaire (PHQ-9)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_

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

	<u>Not at all</u>	<u>Several Days</u>	<u>More Than Half the Days</u>	<u>Nearly Every Day</u>
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:**

<p><b>10.</b> 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?</p>	<p><b>Not difficult at all</b> _____</p> <p><b>Somewhat difficult</b> _____</p> <p><b>Very difficult</b> _____</p> <p><b>Extremely difficult</b> _____</p>
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