

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

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

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

**(Circle to indicate your answer)**

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 or watching television	0	1	2	3
8. Moving or speaking so slowly that 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
<b>FOR OFFICE SCORING ONLY -----TOTAL</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?**

<b>Not difficult at all</b>	<b>Somewhat difficult</b>	<b>Very difficult</b>	<b>Extremely difficult</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>