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 or check 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** ☐
FOR OFFICE SCORING ONLY ---------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
☐	☐	☐	☐