

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

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

### ***Patient Health Questionnaire (PHQ-9)***

1. Over the last two weeks how often have you been bothered by any of the following problems?

	<b>Not at all</b> (0)	<b>Several days</b> (1)	<b>More than half the days</b> (2)	<b>Nearly every day</b> (3)
a. Little interest or pleasure in doing things.				
b. Feeling down, depressed, or hopeless.				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating.				
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.				
g. Trouble concentrating on things, such as reading the newspaper or watching TV.				
h. 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 more than usual.				
i. Thoughts that you would be better off dead or of hurting yourself in some way.				

**Total Score:** \_\_\_\_\_

2. If you checked off any problem on this questionnaire so far, 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