

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

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

Date of Birth: \_\_\_\_\_

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

Over the last 2 weeks, how often have you been bothered by any of the following problems? <i>(Use "x" to indicate your answer)</i>	Not at all	Several days	More than half the days	Nearly every day
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
<b>add columns</b>				
<b>Total</b>				

10. 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** \_\_\_\_\_