

Patient Health Questionnaire – PHQ-9

Name _____ D.O.B. _____

Physician _____ Date _____

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

		Not At All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
1.	Feeling down, depressed or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Trouble falling or staying asleep, or sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Feeling tired or having little energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Poor appetite or overeating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Feeling bad about yourself—or that you are a failure--or have let yourself or your family down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Trouble concentrating on things, such as reading the newspaper or watching television?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Thoughts that you would be better off dead or thoughts of hurting yourself in some way?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Office Use Only

Number of shaded boxes checked: _____ Severity Score: (Total of all scores above) _____

10. If you are experiencing any of the problems on this form, 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?

- 0 — Not difficult at all
 1 — Somewhat difficult
 2 — Very difficult
 3 — Extremely difficult

11. In the past two years, have you felt depressed or sad most days, even if you felt okay sometimes?

- Yes
 No

*** If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with our doctor, go to a hospital emergency room or call 911.*

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Function score: (response to question 10) _____

07/02

For Office Use Only:

Number of Depressive symptoms: (Diagnosis)

1. For questions 1-8, count the number of symptoms the patient checked as "more than half the days" or "nearly every day." For question 9, count the question positive if the patient checks "several days," "more than half the days," or nearly every day."
2. Use the following interpretation grid to diagnose depression subtypes:

0-2 symptoms	Not clinically depressed
3-4 symptoms	Other depressive syndrome
5 or more symptoms	Major depressions

****PHQ items #1 or #2 must be one of the symptoms checked.**

Severity Score:

1. Assign a score to each response by the number value under the answer headings (not all=0; several days =1; more than half the days=2; and nearly every day=3).
2. Total values for each response to obtain the severity score.
3. Use the following interpretation grid.

0-4	Not clinically depressed
5-9	Mild Depression
10-14	Moderate Depression
15 or greater	Severe Depression

**Self Care Screening
Depression Awareness Survey**

A) During the past month have you often been bothered by:

1) Little interest or pleasure in doing things? Yes No

2) Feeling down, depressed or hopeless? Yes No

Or

3) Have you been diagnosed or treated for depression in the past two years? Yes No

B) If you answered yes to any of the above questions, please complete the questionnaire on the other side of this page.

