PHQ-9 PATIENT HEALTH QUESTIONNAIRE

Patient Name _____ **Date** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer.)*

	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 asleep, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having low 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
add columns:		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

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 people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

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