Stellar Medical Group

9197 W THUNDERBIRD RD STE 101
PEORIA AZ 85381-4922
Ph: 623-900-5181 Fax:(623) 900-5290
www.stellarmgaz.com

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Date Of Appt:_____ **Name:**_____ **Date of Birth :** _____

Over the last 2 weeks how often have you been bothered by any of the following problems?

(Use "x" to indicate your answer)

	Not at all	Several Days	More than half days	Nearly Every day
	0	1	2	3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

Total Score: ☐

List any providers and/or specialists you re currently seeing:

Provider Name	Facility Name	Diagnosis Treated/Specialty

Provider Reviewed:_____ **Date:**_____