

**AFROUZ GERAYLI, M.D., INC.**  
**500 Paseo Camarillo, Suite 100, Camarillo CA 93010**

**PATIENT HEALTH QUESTIONNAIRE**

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

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

	Not at all	Several days	More than ½ 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 over eating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure or have let your family down	0	1	2	3
7. Trouble concentrating on things, such as reading 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

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 \_\_\_\_\_

Total: \_\_\_\_\_

0-4 No Depression  
 5-9 Mild Depression  
 10-14 Moderate Depression  
 15-19 Moderately severe Depression  
 20-27 Severe Depression