



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Insurance: _____ Member Plan ID: _____ Today's Date: _____

Practice Name: Gand K Medical Associates TIN: 270050381

Name: _____ Date of Birth: _____ Sex: M F

ZIP Code: _____ Mobile number: _____ Email: _____

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

		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
3	Feeling down, depressed or hopeless	0	1	2	3
4	Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
5	Feeling tired or having little energy	0	1	2	3
6	Poor appetite or overeating	0	1	2	3
7	Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
8	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
9	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

Column Totals: _____ + _____ + _____

Add Totals Together: _____

10 If you checked off any problems, how difficult have those 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

For office coding: 0 + + + = Total Score