Patient Health Questionnaire

(PHQ-9 - Modified for Adolescents)

Name: Date:

Instructions: For each of the following questions, check the box below the answer that best describes how you have been feeling **during the past two weeks**.

1. Feeling down, depressed, irritable, or hopeless?	Select option
2. Little interest or pleasure in doing things?	Select option
3. Trouble falling asleep, staying asleep, or sleeping too much?	Select option
4. Poor appetite, weight loss, or overeating?	Select option
5. Feeling tired, or having little energy?	Select option
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	Select option
7. Trouble concentrating on things like school work, reading, or watching TV?	Select option
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being unusually fidgety or restless?	Select option
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	Select option

In the past year have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

How difficult have the problems above (if any) 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

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐ Yes ☐ No

Office use:

Symptom severity score: 0