**NYCCC**

**Patient Health Questionnaire-9**

**Please circle one response for each item.**

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| --- | --- | --- | --- | --- |
| **Over the last 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** |
| Little interest or pleasure doing things. | 0 | 1 | 2 | 3 |
| Feeling down, depressed or hopeless. | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep or sleeping too much. | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy. | 0 | 1 | 2 | 3 |
| Poor appetite or overeating. | 0 | 1 | 2 | 3 |
| Feeling bad about yourself-or that you are a failure or have let yourself or your family down. | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading or watching TV. | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people could have noticed OR the opposite- being so restless that you have been moving around a lot more than usual. | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead or hurting yourself in some way. | 0 | 1 | 2 | 3 |
| *For office codiing* |  |  |  |  |