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PATIENT HEALTH QUESTIONNAIRE (PHQ -9)

PATIENT NAME: _____

NAME OF PERSON COMPLETING FORM: _____

RELATIONSHIP TO PATIENT: _____ DATE: _____

DIRECTIONS: INDICATE THE DEGREE TO WHICH EACH ITEM BELOW HAS BEEN A PROBLEM OVER THE LAST 2 WEEKS. PLEASE RESPOND TO ALL ITEMS BY CHECKING OR CIRCLING THE MOST APPROPRIATE SCORE.

	Never	Sometimes	Often	Very Often
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 OVEREATING	0	1	2	3
6. FEELING BAD ABOUT YOURSELF – OR THAT YOU ARE A FAILURE OR HAVE LET YOURSELF OR YOUR FAMILY DOWN	0	1	2	3
7. TROUBLE CONCENTRATING ON THINGS, SUCH AS READING THE NEWSPAPER 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 THOUGHTS OF HURTING YOURSELF IN SOME WAY	0	1	2	3
SCORE TOTALS:				

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	SOMEWHAT DIFFICULT	VERY DIFFICULT	EXTREMELY DIFFICULT
☐	☐	☐	☐