

# PATIENT HEALTH QUESTIONNAIRE (PHQ) Brief

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

## 1. 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 in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 2. Questions about anxiety.

	YES	NO
In the last 4 weeks, have you had an anxiety attack— suddenly feeling fear or panic? If you checked "NO," go to question 3.	<input type="checkbox"/>	<input type="checkbox"/>
Has this ever happened before?	<input type="checkbox"/>	<input type="checkbox"/>
Do some of these attacks come suddenly out of the blue—that is, in situations where you don't expect to be nervous or uncomfortable?	<input type="checkbox"/>	<input type="checkbox"/>
Do these attacks bother you a lot or are you worried about having another attack?	<input type="checkbox"/>	<input type="checkbox"/>
During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	<input type="checkbox"/>	<input type="checkbox"/>

## 3. If you checked off any problems on this questionnaire so far, 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

FOR OFFICE CODING: Maj Dep Syn if answer to #1a or b and five or more of # 1a–i are at least "More than half the days" (count #1i if present at all). Other Dep Syn if #1a or b and two, three, or four of #1a–i are at least "More than half the days" (count #1i if present at all). Pan Syn if all of #2a–e are "YES."

**4. In the last 4 weeks, how much have you been bothered by any of the following problems?**

	NOT BOTHERED	BOTHERED A LITTLE	BOTHERED A LOT
Worrying about your health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your weight or how you look	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Little or no sexual desire or pleasure during sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The stress of taking care of children, parents, or other family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress at work outside of the home or at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial problems or worries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having no one to turn to when you have a problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Something bad that happened recently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking or dreaming about something terrible that happened to you in the past—like your house being destroyed, a severe accident, or being hit or assaulted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5. In the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?**  YES  NO

**6. What is the most stressful thing in your life right now?** \_\_\_\_\_

**7. Are you taking any medication for anxiety, depression, or stress?**  YES  NO

**8. FOR WOMEN ONLY:** Questions about menstruation, pregnancy, and childbirth.

a. Which best describes your menstrual periods?

- |   |  |
|---|--|
| <input type="checkbox"/> PERIODS ARE UNCHANGED  | <input type="checkbox"/> NO PERIODS FOR AT LEAST A YEAR  |
| <input type="checkbox"/> NO PERIODS BECAUSE PREGNANT OR RECENTLY GAVE BIRTH                         | <input type="checkbox"/> HAVING PERIODS BECAUSE TAKING HORMONE REPLACEMENT (ESTROGEN) THERAPY OR ORAL CONTRACEPTIVES |
| <input type="checkbox"/> PERIODS HAVE BECOME IRREGULAR OR CHANGED IN FREQUENCY, DURATION, OR AMOUNT |  |

b. During the week before your period starts, do you have a serious problem with your mood—like depression, anxiety, irritability, anger, or mood swings?  YES  NO (or does not apply)

c. If YES, do these problems go away by the end of your period?  YES  NO

d. Have you given birth within the last 6 months?  YES  NO

e. Have you had a miscarriage within the last 6 months?  YES  NO

f. Are you having difficulty getting pregnant?  YES  NO