

# BRIEF PATIENT HEALTH QUESTIONNAIRE (Brief PHQ)

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.

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex:  Female  Male Today's Date \_\_\_\_\_

**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         |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Little interest or pleasure in doing things  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Feeling down, depressed, or hopeless   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Trouble falling or staying asleep, or sleeping too much  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Feeling tired or having little energy  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Poor appetite or overeating  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. 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"/> |
| g. Trouble concentrating on things, such as reading the newspaper or watching television  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. 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"/> |
| i. 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.**

|  | NO                       | YES                      |
|--|--------------------------|--------------------------|
| a. In the <u>last 4 weeks</u> , have you had an anxiety attack—suddenly feeling fear or panic?   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If you checked "NO," go to question 3.</b>  |                          |                          |
| b. Has this ever happened before?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do some of these attacks come <u>suddenly out of the blue</u> —that is, in situations where you don't expect to be nervous or uncomfortable?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do these attacks bother you a lot or are you worried about having another attack?   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. 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

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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           |
|--|--------------------------|--------------------------|--------------------------|
| a. Worrying about your health  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Your weight or how you look   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Little or no sexual desire or pleasure during sex   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The stress of taking care of children, parents, or other family members   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Stress at work outside of the home or at school   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Financial problems or worries   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Having no one to turn to when you have a problem  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Something bad that happened <u>recently</u>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Thinking or dreaming about something terrible that happened to you <u>in the past</u> —like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act | <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, or has anyone forced you to have an unwanted sexual act?

NO YES

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

7. Are you taking any medication for anxiety, depression, or stress?

NO YES

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

a. Which best describes your menstrual periods?

- Periods are unchanged**    
 **No periods because pregnant or recently gave birth**    
 **Periods have become irregular or changed in frequency, duration, or amount**    
 **No periods for at least a year**    
 **Having periods because taking hormone replacement (estrogen) therapy or oral contraceptives**

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?

NO YES  
(or does not apply)

c. If YES, do these problems go away by the end of your period?

d. Have you given birth within the last 6 months?

e. Have you had a miscarriage within the last 6 months?

f. Are you having difficulty getting pregnant?

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