

The Patient Health Questionnaire PHQ-9

Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems? For each symptom, put an **X** in the box beneath the answer that best describes how you have been feeling.

	Not at All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling asleep, staying asleep, or sleeping too much				
4. Feeling tired, or having little energy				
5. Poor appetite, weight loss, or overeating				
6. Feeling bad about yourself – or that you’re a failure, or have let yourself or your family down				
7. Trouble concentrating on things such as reading the newspaper, or watching TV				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				

Column Totals _____ + _____ + _____ :

Add Totals Together _____

10. If you checked off any problems, how difficult have those 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