The Patient Health Questionnaire (PHQ-9)

Patient Name: _____ Date of Birth: _____
Date of Visit: _____

Over the past 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
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 asleep, 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're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading 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 of hurting yourself in some way	0	1	2	3

Total: _____

Additional assessment questions:

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 others:

☐ Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

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11. In the last two weeks, have you experienced excessive worry, nervousness, or anxiety? ☐ No
Yes- Rate severity: ☐ Mild ☐ Moderate ☐ Severe

12. Any misuse of illegal substances, alcohol, or prescription medications: No ____ Yes_____

13. Do you need any refills today? Medication: _____