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# Patient Health Questionnaire (PHQ-9)

Name: ______________________________ Date of Visit: _________________

| Over the past two weeks, how often have you been bothered by any of the following problems? (Please CIRCLE to indicate your answer) | 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, irritable, or hopeless? | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying a sleep, 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 school work, 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 Score