Patient Questionnaire (PHQ-9)

Patient Information				
Date of Service:				
Patient Name:				
Date of Birth:				
Sex:				
Questionnaire				
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle your answers)	**Not at all**	**Several days**	**More than half the days**	**Nearly Everyday**
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, or sleeping too much	0	1	2	3
4. Feeling tired or having a little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling badly about yourself, or feeling that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper 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
Please calculate totals for each column and combine for Total Score.	0			

If you checked off any of the above problems, how difficult have these problems made it for 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

Total Score	

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