Patient Health Questionnaire (PHQ-9)

(CONFIDENTIAL, TO BE FILLED OUT BY TEEN ONLY**)**

Patient's Name: _____ **Age**:_____

Today's Date: _____

Over the past 2 weeks, how often have you been Bothered by any of the following problems? (Please circle to indicate your answer)

	Not at all	Several Day	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 or 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 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. Thought that you would be better off dead, or of hurting yourself	0	1	2	3

10. If you checked off any problems, 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

---

FOR OFFICE USE ONLY*

Total Colum Score: _____

1-4	**5-9**	**10-14**	**15-19**	**20-27**
Minimal	Mild	Moderate	Moderately Severe	Severe

Comments: _____

_____

_____

_____