PATIENT HEALTH QUESTIONNAIRE 9 (PHQ9)

Name _____ Date _____

Over the last **TWO 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**
	0	**1**	**2**	**3**
1. Feeling down, depressed, irritable or helpless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss or overeating?				
5. Feeling tired or having little energy?				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down?				
7. Trouble concentrating on things, such as schoolwork, reading 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've been moving around a lot more than usual?				
9. Thoughts that you would be better off dead or of hurting yourself in some way?				
SUB-TOTAL				
TOTAL				

Has there been a time in the past **MONTH** when you have had serious thoughts about ending your life?	Yes	No
In the **PAST YEAR** have you felt depressed or sad most days, even if you felt OK sometimes?	Yes	No
Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?	Yes	No

If you have experienced any of the problems on this form, 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

OFFICE USE ONLY

☐ *Start*
☐ *Completion*

SCORING	☐ *1-4*	*Minimal depression*
	☐ *5-9*	*Mild depression*
	☐ *10-14*	*Moderate depression (≥11 = positive score)*
	☐ *15-19*	*Moderately severe depression*
	☐ *20-27*	*Severe depression*

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