



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last two weeks, how often have you been bothered by any of the following problems?

Please check mark to indicate your answer.

	Not at all	Several days	More than half days	Nearly everyday
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
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 reading the newspaper or watching television				
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				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				

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?	<input type="checkbox"/> Not difficult at all
	<input type="checkbox"/> Somewhat difficult
	<input type="checkbox"/> Very difficult
	<input type="checkbox"/> Extremely difficult