

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____

Date: _____

In order to comply with the national standard of care, we ask that you complete this survey as an integral part of your well visit. As is true with other provided services such as lab tests and vaccines, you may be responsible for any billable charges not covered by your insurance carrier. Thank you in advance for your cooperation.

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Choose an answer of Not at all, Several days, More than half the days, or Nearly every day.

- | | Not at all | Several days | More than half the days | Nearly every day |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Little interest or pleasure in doing things | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Feeling down, depressed, or hopeless | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Trouble falling or staying asleep, or sleeping too much | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Feeling tired or having little energy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Poor appetite or overeating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Feeling bad about yourself--or that you are a failure or have let yourself or your family down | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

(Healthcare professional: For interpretation of TOTAL, Please refer to accompanying scoring card.)

TOTAL: 0

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