

PATIENT HEALTH QUESTIONNAIRE (PHQ9) 11+

Name: _____

Provider : _____

Date of Birth: _____

Age: _____

Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(please circle number to indicate your answer)

	Not at all	Several Days	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 sleep 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 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 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	0	1	2	3

Add columns _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to the accompanying scorecard)

TOTAL:

10. If you have 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 _____
 Very difficult _____
 Extremely difficult _____
 Somewhat difficult _____