

Patient Health Questionnaire – 9 (PHQ-9)

Name: _____

Date of Birth: _____

Today's Date: _____

Over the last 2 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

| | | | | |
|---|--|--------------------------|--------------------------|--------------------------|
| 1. Little interest or pleasure in doing things | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Feeling down, depressed, irritable 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 school work, reading 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"/> |
| 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? | <p>Not difficult at all <input type="checkbox"/></p> <p>Somewhat difficult <input type="checkbox"/></p> <p>Very difficult <input type="checkbox"/></p> <p>Extremely difficult <input type="checkbox"/></p> | | | |