Patient Health Questionnaire 9-item   **To Be Completed By Patient**
                                                                      Form PHQ9

Patient Name		Date of Assessment			
To be completed by the Patient					
1. Over the last 2 weeks, how often have you bee bothered by any of the following problems? (Use a "x" to indicate your answer")		**Not at all (0)**	**Several Days (1)**	**More Than Half the days (2)**	**Nearly Every Day (3)**
a) Little interest or pleasure in doing things					
b) Feeling down, depressed or hopeless					
c) Trouble falling or staying asleep, or sleeping too much					
d) Feeling tired or having little energy					
e) Poor appetite or overeating					
f) Feeling bad about yourself - or that you are a failure or have let yourself or your family down					
g) Trouble concentrating on things such as reading the newspaper or watching television					
h) 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					
i) Thoughts that you would be better off dead, or of hurting yourself in some way					
	add columns	0	0	0	0
	TOTAL	0			

2. 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	Not difficult at all	
	Somewhat difficult	
	Very Difficult	
	Extremely Difficult	

0-4 No depression   15-19 Moderate Symptoms

5-9 Minimal Symptoms   >20 Severe Symptoms

10-14 Mild Symptoms

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