Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Health Questionnaire- PHQ 9**

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 | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 1. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself- or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 1. 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 | 0 | 1 | 2 | 3 |
| 1. Thoughts that you would be better off dead or hurting yourself in some way | 0 | 1 | 2 | 3 |

Please total your score. Total Score: \_\_\_\_\_\_ = \_\_\_\_\_\_ + \_\_\_\_\_\_ + \_\_\_\_\_\_ + \_\_\_\_\_\_\_\_