# Patient Health Questionnaire (PHQ-9)

**Patient Name:** _____ **Date:** _____

**This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer questions 1 – 10.**

| | **Over the last 2 weeks, how often have you been bothered by:** | Not at all 0 | Several days 1 | More than half the days 2 | Nearly every day 3 |
|---|---|---|---|---|---|
| 1. | Little interest or pleasure in doing things | | | | |
| 2. | Feeling down, depressed, or hopeless | | | | |
| 3. | Trouble falling or staying asleep, or sleeping too much | | | | |
| 4. | Feeling tired or having little energy | | | | |
| 5. | Poor appetite or overeating | | | | |
| 6. | Feeling bad about yourself-or that you are a failure or have let yourself or your family down | | | | |
| 7. | Trouble concentrating on things, such as reading the newspaper or watching television | | | | |
| 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 | | | | |
| 9. | Thought that you would have been better off dead or of hurting yourself in some way | | | | |
| *For your doctor to complete:* | Subtotals | | | | |
| | TOTAL SCORE | | | | |

10. If you checked off any problems on this questionnaire so far, 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



Form reviewed by: _____