**Patient Name: Date:**

**Patient Health Questionnaire (PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

**1. Little interest or pleasure in doing things?**

**a.** Not at all **b.** Several days **c.** More than half the days **d.** Nearly everyday

**2. Feeling down, depressed, or hopeless**

**a.** Not at all **b.** Several days **c.** More than half the days **d.** Nearly everyday

**3. Trouble falling or staying asleep, or sleeping too much**

**a.** Not at all **b.** Several days **c.** More than half the days **d.** Nearly everyday

**4. Feeling tired or having little energy**

**a.** Not at all Several days **c** More than half the days Nearly everyday

**5. Poor appetite or overeating**

**a.** Not at all **b.** Several days **c.** More than half the days Nearly everyday

**6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down**

**a.** Not at all Several days **c** More than half the days  Nearly everyday

**7. Trouble concentrating on things, such as reading the newspaper or watching TV**

**a.** Not at all **b.** Several days **c.** More than half the days **d.** Nearly everyday

**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**

**a.** Not at all **b.** Several days **c.** More than half the days Nearly everyday

**9. Thoughts that you would be better dead, or of hurting yourself in some way**

**a.** Not at all **b.** Several days **c.** More than half the days  Nearly everyday

**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 others?**

**a.**  Not difficult at all Somewhat difficult  Very difficult Extremely difficult