Patient Health Questionnaire-PHQ

Nine Symptom Depression Checklist

Patient Name: _____ Date: _____

Patient DOB: _____ Practice: _____

	Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3	Score
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	Thoughts that you would be better off dead, or of hurting yourself in some way.					
					Total	

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**
O	**O**	**O**	**O**

Total number of symptoms _____ Total score _____