

Date: _____

Depression Questionnaire (PHQ9)



Patient Name: _____ Birth Date: _____

Name of person helping the patient complete this form? _____

PHQ-9 (Depression)				
Not at all	Many days	More than half the days	Nearly every day	Over the last 2 weeks, how often have you been bothered by any of the following problems?
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	1. Little interest or pleasure in doing things
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	2. Feeling down, depressed or hopeless
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	3. Trouble falling or staying asleep or sleeping too much
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	4. Feeling tired or having little energy
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	5. Poor appetite or overeating
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	6. Feeling bad about yourself – or that you’re a failure or let yourself or you family down
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	7. Trouble concentrating on things, such as reading the newspaper or watching television
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you’ve been moving around more than usual.
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	9. Thought that you would be better off dead or of hurting yourself in some way
Total Score =				
Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult <input type="checkbox"/>				If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?