

Patient Health Questionnaire—PHQ-9

Name: _____ Date of Birth : _____ Today's Date: _____

Fill in the boxes with pen or pencil to mark your answers.

A. 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
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Score _____ = _____ + _____ + _____ + _____				

B. If you have been bothered by any of the 9 problems listed above, please answer the following:

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

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A Survey From Your Healthcare Provider — PHQ-9 Modified for Teens

Name _____ Clinician _____

Medical Record or ID Number _____ Date _____

**Instructions: How often have you been bothered by each of the following symptoms during the past two weeks?
For each symptom put an “X” in the box beneath the answer that best describes how you have been feeling.**

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? Yes No

11. If you are experiencing any of the problems on this form, 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

12. Has there been a time in the past month when you have had serious thoughts about ending your life? Yes No

13. Have you **ever**, in your **whole life**, tried to kill yourself or made a suicide attempt? Yes No

FOR OFFICE USE ONLY Score _____

Q. 12 and Q. 13 = Y or TS = ≥11