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

**Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**(Use “x” to indicate your answer)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all = 0 | Several days =1 | More than half the days = 2 | Nearly every day  = 3 |
| 1) Trouble falling asleep, or sleeping to much |  |  |  |  |
| 2) Little interest or pleasure in doing things |  |  |  |  |
| 3 a)-Feeling bad about yourself – or that you are a failure or have let yourself or your family down |  |  |  |  |
| 3 b) Feeling down, depressed, or hopeless |  |  |  |  |
| 4) Feeling tired or having little energy |  |  |  |  |
| 5) Trouble concentrating on things, such as reading the newspaper or watching television |  |  |  |  |
| 6) Poor appetite or overeating |  |  |  |  |
| 7) 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 |  |  |  |  |
| 8) Thoughts that you would be better off dead, or of hurting yourself in some way |  |  |  |  |
| TOTAL |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all difficult | Somewhat difficult | Very difficult | Extremely difficult |
| 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? |  |  |  |  |