

Patient Health Questionnaire – PHQ 9
 Nine Symptom Depression Checklist

Date: _____ **Patient's Name:** _____
DOB: _____ **I.D. Number:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	“Not at all” (score: 0)	“Several days” (score: 1)	“More than half the days” (score: 2)	“Nearly every day” (score: 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					Thought that you would be better off dead, or of hurting yourself in some way

Total number of symptoms: Total score:

Thinking about the problems you have ticked above, how difficult have these problems made it for you to work; take care of things at home; or get along with other people?

(Tick the appropriate box below):

Not Difficult At All	Fairly Difficult	Very Difficult	Extremely Difficult
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