PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: **Date:**

Over the *last 2 weeks,* how often have you been bothered by any of the following problems? (use "√" to indicate your answer)	Not at all	Several days	More than ha. the days	Nearly every day
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				
	add colums:		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	**Total:**			
10. Have you ever had so much energy that you did not sleep for 2-3 days?				

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 _____