

# Patient Health Questionnaire (PHQ - 9)

Date Completed (mm/dd/yyyy)

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Time of Administration:

Admission  
 During Treatment.....  
 Discharge

Days  
 Weeks  
 Months

} since Admission



Be sure to fill in all choices with  not

Over the last week, how often have you been bothered by the following problems?

Please place an X in the box below your answer.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	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 or staying asleep, or 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"/>

For office coding:      0   +      +      +      +     

= TOTAL SCORE:

(add up each item)

10. 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

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Patient Account Number

1	0	1
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Program Code

Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

