

Patient Health Questionnaire-9 (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by the following problems? Please circle the number that best applies.

	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	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or feeling like a failure	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or being so fidgety or restless that you have been moving around more than usual	0	1	2	3
9. Thoughts that you would be better off dead or harming yourself in some way	0	1	2	3

Total Score: _____

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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