**Patient Health Questionnaire (PHQ9)**

**Patient Name:**  **Date:**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **(Use a Checkmark to indicate your answer)** | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| 1. Little interest or pleasure in doing thing
 | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed or hopeless
 | 0 | 1 | 2 | 3 |
| 1. Trouble falling or staying asleep, or sleeping too much
 | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy
 | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating
 | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself-or that you are a failure or have let yourself or your family down
 | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television
 | 0 | 1 | 2 | 3 |
| 1. 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
 | 0 | 1 | 2 | 3 |
| 1. Thoughts that you would be better off dead or hurting yourself in some way
 | 0 | 1 | 2 | 3 |

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 **Total Score**

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