**Patient Health Questionnaire—PHQ-9**

Initials: \_\_\_\_\_\_\_\_\_ Date of Birth :\_\_\_\_\_\_\_\_ Today’s 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 half the days | Nearly every day |
| 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 that you are a failure or have let yourself or your family down. | 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 the opposite — being so fidgety or restless that you have been moving around a lot more than usual. | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way. | 0 | 1 | 2 | 3 |

0 + \_\_\_\_\_\_ + \_\_\_\_\_\_ + \_\_\_\_\_\_

=Total Score: \_\_\_\_\_\_

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