Patient Health Questionnaire (PHQ-9)

We strive to screen every patient at least once a year for depression. As providers, we often do not know if someone is being impacted by depression unless we ask. And the symptoms are more severe than we realize. We are here to help in any way we can, including in helping any patient deal with depression. Please take a moment to complete the below.

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**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 asleep, 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're 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 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

Column Totals_____ + _____ + _____ + _____

Add Totals Together:_____

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10. If you checked off any problems, how difficult have those 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

Patient Name: _____ Patient DOB: _____

Person who completed form: _____ Date: _____

Provider Name: _____ M.D. / D.O. / N.P. / P.A.

Provider Signature: _____ M.D. / D.O. / N.P. / P.A.