Patient Health Questionnaire – PHQ 9

Nine Symptom Depression Checklist

Date: **Patient's Name:**

DOB: **I.D. Number:**

Over the last 2 weeks, how often have you been bothered by any of the following problems?		"Not at all" (score: 0)	"Several days" (score: 1)	"More than half the days" (score: 2)	"Nearly every day" (score: 3)	Score:
1	Little interest or pleasure in doing things					
2	Feeling down, depressed or hopeless					
3	Trouble falling or staying asleep or sleeping too much					
4	Feeling tired or having little energy					
5	Poor appetite or overeating					
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down					
7	Trouble concentrating on things, such as reading the newspaper or watching television					
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					
9	Thought that you would be better off dead, or of hurting yourself in some way					

Total number of symptoms: ☐ **Total score:** ☐

Thinking about the problems you have ticked above, how difficult have these problems made it for you to work; take care of things at home; or get along with other people?
(Tick the appropriate box below):

Not Difficult At All	Fairly Difficult	Very Difficult	Extremely Difficult