

MRN:  
Patient Name:

(Patient Label)

**PATIENT HEALTH QUESTIONNAIRE (PHQ-9)**

Over the last two weeks, how often have you been bothered by any of the following problems? Please CHECK one.	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling bad about yourself or that you are a failure, or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Thoughts that would be better off dead or of hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<b><u>For Staff Use Only</u></b>				
<b>Total _____ =</b>	_____	+ _____	+ _____	+ _____

Patient or Representative Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

If signed by someone other than the patient, please specify relationship to the patient: \_\_\_\_\_

Physician Signature \_\_\_\_\_ ID# \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Interpreter Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ ID: \_\_\_\_\_