UCLA Health

MRN:
Patient Name:

(Patient Label)

PATIENT QUESTIONNAIRE: PHQ9

Over the **last 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 of pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble fall 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 hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3
	____ +	____ +	____ +	_____=
			Total score:	_____

If you checked off any problems, how difficult have these 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
☐ 0	☐ 1	☐ 2	☐ 3

Patient or Representative Signature _____ Date _____ Time _____

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

Interpreter Signature _____ ID # _____ Date _____ Time _____

Provider Signature _____ Title # _____ Date _____ Time _____