

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ACCT#

CLIENT NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(please circle the number to indicate your answer)

- 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. Thoughts that you would be better off dead, or of hurting yourself**

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3

Add Columns	+	+	+
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TOTAL: _____

10. If you checked off any problems above, 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 _____

11. Do you or does anyone else have concern about your alcohol or drug use? Yes No

12. Do you use tobacco? Yes No
If so, are you interested in quitting? Yes No

This space for clinician use

CLINICIAN INTIALS: _____
 C.R.