PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 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 figety 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	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 _____

A2663B 10-04-2005

WORKSHEET 10.1: *Mind Over Mood* Depression Inventory

In order to use this inventory multiple times, do not write on this page. Indicate on the answer sheet on the following page the numbered answer that best describes how much you have experienced each symptom over the last week.

	Not at all	Sometimes	Frequently	Most of the time
1. Sad or depressed mood	0	1	2	3
2. Feeling guilty	0	1	2	3
3. Irritable mood	0	1	2	3
4. Less interest or pleasure in usual activities	0	1	2	3
5. Withdraw from or avoid people	0	1	2	3
6. Find it harder than usual to do things	0	1	2	3
7. See myself as worthless	0	1	2	3
8. Trouble concentrating	0	1	2	3
9. Difficulty making decisions	0	1	2	3
10. Suicidal thoughts	0	1	2	3
11. Recurrent thoughts of death	0	1	2	3
12. Spend time thinking about a suicide plan	0	1	2	3
13. Low self-esteem	0	1	2	3
14. See the future as hopeless	0	1	2	3
15. Self-critical thoughts	0	1	2	3
16. Tiredness or loss of energy	0	1	2	3
17. Significant weight loss or decrease in appetite (do not include weight loss from a diet plan)	0	1	2	3
18. Change in sleep pattern—difficulty sleeping or sleeping more or less than usual	0	1	2	3
19. Decreased sexual desire	0	1	2	3

Score (of total circled numbers) ☐