

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

CLIENT NAME:		DATE:		
Overthelast 2 weeks, how often have you been bothered by any of the following problems? (please circle the number 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 oppositebeing 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 of hurting yourself	0	1	2	3
A	dd Columns	4	(+	
	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 difficultat all Somewhat difficult Very difficult Extremely difficult		
11. Do you or does anyone else have concern about yo	ur alcohol o	r drug use?	□Yes □ No	
12. Do you use tobacco? □ Yes □ No If so, are you interested in quitting? □ Yes □ No				