Patient Health Questionnaire—PHQ-9

Name: _____ Date of Birth: _____ Today's Date: _____

Fill in the boxes with pen or pencil to mark your answers.

A. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things	❑	❑	❑	❑
2. Feeling down, depressed, or hopeless	❑	❑	❑	❑
3.Trouble falling/staying asleep, 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 in some way	❑	❑	❑	❑
Total Score ____ =	____+	____+	____+	____

B. If you have been by any of the 9 problems listed above, please answer the following:

How difficult have the 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
❑	❑	❑	❑

This health survey was adapted from the PRIME-MD® Patient Health Questionnaire © 1999, Pfizer Inc.Reproduced with permission. For research information,contact Dr.Robert L. Spitzer at rls8@columbia.edu.