



MEDICAL RECORD#

DOB

NAME

VISIT#

PATIENT HEALTH QUESTIONNAIRE-9

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?
Read each item carefully, and ✓ your response.

	Not at all	Several days	More than half the days	Nearly every day	
	0	1	2	3	
a. Little interest or pleasure in doing things					
b. Feeling down, depressed, or hopeless					
c. Trouble falling asleep, staying asleep, or sleeping too much					
d. Feeling tired or having little energy					
e. Poor appetite or overeating					
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down					
g. Trouble concentrating on things, such as reading the newspaper or watching television					
h. 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					
i. Thoughts that you would be better off dead or of hurting yourself in some way					
Totals			+	+	=

2. If you checked off any problem on this questionnaire so far, 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 at all _____ Several days _____ Very difficult _____ Extremely difficult _____

You may contact me at () _____ - _____ to talk about studies that focus on these feelings. _____ (Initials)

Thank you for filling out this form!!!

For staff use only **Check if score > 10 indicating clinical evaluation**

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____ Military Time: _____