



## PATIENT HEALTH QUESTIONNAIRE

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Part of routine screening for your health includes reviewing mood and emotional concerns. Please answer each question as honestly as possible.

### PHQ-2 Screening

**During the past two weeks**, have you often been bothered by the following problems?

1. Feeling down, depressed, irritable, or hopeless?     Yes     No
2. Little interest or pleasure in doing things?     Yes     No

**If you answered “Yes” to either question above, please complete the PHQ-9 below.**

### PHQ-9 Assessment

Over the past 2 weeks, how often have you been bothered by 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, irritable, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Poor appetite, weight loss, or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself — or feeling you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, like reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## PATIENT HEALTH QUESTIONNAIRE

Over the past 2 weeks, how often have you been bothered by the following problems?	Not at All (0)	Several Days (1)	More Than Half the Days (2)	Nearly Every Day (3)
more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home, or get along with others?

Not difficult at all   
  Somewhat difficult   
  Very difficult   
  Extremely difficult

<b>For Office Use Only – Total Score:</b>	
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*PHQ-2 and PHQ-9 adapted tool*