Depression Screening (PHQ-9)

Please complete all fields, save this file, and email it back to us — or print and bring it to your visit.

Patient Name

Date

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

1. Little interest or pleasure in doing things

☐ Not at all ☐ Several days ☐ More than half ☐ Nearly every day

2. Feeling down, depressed, or hopeless

☐ Not at all ☐ Several days ☐ More than half ☐ Nearly every day

3. Trouble falling or staying asleep, or sleeping too much

☐ Not at all ☐ Several days ☐ More than half ☐ Nearly every day

4. Feeling tired or having little energy

☐ Not at all ☐ Several days ☐ More than half ☐ Nearly every day

5. Poor appetite or overeating

☐ Not at all ☐ Several days ☐ More than half ☐ Nearly every day

6. Feeling bad about yourself — or that you are a failure, or have let yourself or your family down

☐ Not at all ☐ Several days ☐ More than half ☐ Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

☐ Not at all ☐ Several days ☐ More than half ☐ Nearly every day

8. Moving or speaking so slowly that other people could have noticed — or being fidgety/restless

☐ Not at all ☐ Several days ☐ More than half ☐ Nearly every day

9. Thoughts that you would be better off dead, or of hurting yourself in some way

☐ Not at all ☐ Several days ☐ More than half ☐ Nearly every day

FINAL QUESTION

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 difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Patient Signature (type full name)

Date