PHQ9P

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PATIENT HEALTH QUESTIONNAIRE-9

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Were data collected? **No** ☐ *(provide reason in comments)*

If **Yes**, data collected on visit date ☐ **or** specify date: ________________
DD-Mon-YYYY

Comments:

Only the patient (subject) should enter information onto this questionnaire.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**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 opposite — being 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 in some way	0	1	2	3

SCORING FOR USE BY STUDY PERSONNEL ONLY

0 + _______ + _______ + _______

=Total Score: _______

If you checked off any problems, 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**
☐	☐	☐	☐

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I confirm this information is accurate.	Patient's/Subject's initials:	Date:

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