

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:

DATE:

**Instructions:** Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "X" to indicate your answer)

|   | 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 YOU OR YOUR FAMILY DOWN  | 0   | 1            | 2                       | 3                |
| 7. TROUBLE CONCENTRATING ON THINGS, SUCH AS READING THE NEWSPAPER OR WATCHING TV  | 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                |
| <b>COLUMN TOTAL</b>   |   |              |                         |                  |
| <b>TOTAL</b>  |   |              |                         |                  |
| 10. IF YOU CHECKED OFF ANY PROBLEMS, HOW DIFFICULT HAVE THESE PROBLEMS MADE IT FOR YOU TO WORK, TAKE CARE OF THINGS AT HOME, OR GET ALONG WITH OTHER PEOPLE?                | <input type="checkbox"/> Not difficult at all<br><input type="checkbox"/> Somewhat difficult<br><input type="checkbox"/> Very Difficult<br><input type="checkbox"/> Extremely difficult |              |                         |                  |

The best telephone number to reach me at is:(\_\_\_\_\_)\_\_\_\_\_

For my prescription (CHECK one)

Please call it into \_\_\_\_\_

Please mail it to my home address

I will have the pharmacy call or contact your office.

**PRESCRIPTIONS CAN NOT BE CALLED IN WHEN THE OFFICE IS CLOSED. CALL YOUR PHARMACY DURING OUR OFFICE HOURS TO MAKE SURE YOUR PRESCRIPTION IS READY.**

OFFICE PHONE: 979-693-0737

OFFICE FAX: 979-693-7442