

**Family Care Physicians, P.C.
Anxiety and Depression Institute
Patient Health Questionnaire Depression (PHQ-9)**

Date: Patient Name: Date of Birth:

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please click the check mark by your answers.**

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Feeling down, depressed, or hopeless.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Feeling tired or having little energy.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Poor appetite or overeating.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. Moving or speaking slowly that others could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Add the score for each column	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Total Score (add your column scores):

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Please check one)

Not difficult at all. **Somewhat difficult.** **Very Difficult.** **Extremely Difficult.**