CAROLINA FAMILY HEALTH CENTERS, INC.

Patient Health Questionnaire -9 (PHQ-9)

Name_____MR#_____DOB_____

Date_____

Over the *last two weeks*, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not At All (0)	Several Days (1)	More Than Half the Days (2)	Nearly Every Day (3)
1. Feeling down, depressed, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Feeling tired or having little energy?	☐	☐	☐	☐
5. Poor appetite or overeating?	☐	☐	☐	☐
6. Feeling bad about yourself--or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
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?	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way?**	☐	☐	☐	☐

10. 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 other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

11. In the past two years, have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

Number of Symptoms_____

Severity _____

** *If you have had thoughts that you would be better off dead or of hurting yourself, please discuss this with your doctor, go to a hospital emergency room or call 911.*