PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name ______________________________ Date ______________

Over the last 2 weeks, how often have you had any of the following problems:	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure and have let yourself or family down	0	1	2	3
Trouble concentrating on things (like reading or watching TV)	0	1	2	3
Moving or speaking too slowly or being restless and moving around a lot more	0	1	2	3
Thoughts you would be better off dead or of hurting yourself	0	1	2	3

Add columns: 0 + ______ + ______ + ______

Total: ______

KEY	
1-4	Minimal Depression
5-9	Mild Depression
10-14	Moderate Depression
15-19	Moderately Sever Depression
20-27	Severe Depression

This document should be reviewed by a clinician and not considered a diagnosis.

Life and Breath Foundation
1-866-4SUPPRT (1-866-478-7778)
www.lifeandbreath.org