PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ **Date:** _____

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 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
		Add Columns _____	**+** ____	**+** ____	***= 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**
☐	☐	☐	☐

PROVIDER SIGNATURE	PRINT NAME	DATE	TIME

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

PATIENT HEALTH QUESTIONNAIRE 9 (PHQ-9)

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