

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT HEALTH QUESTIONNAIRE (PHQ2/9) FOR ADOLESCENTS AND ADULTS

Over the last 7 days, how often have you been bothered by any of the following problems?  
*(please use a check mark (✓) to indicate your answers)*

	Not at all	Several Days	More than Half of the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, irritable or hopeless	0	1	2	3

Total: \_\_\_\_\_

**\*Please total your score from columns answered above. If your total is '2' or lower, PLEASE STOP HERE.**  
 If your score is '3' or higher, please answer questions 3-10 below.

	Not at all	Several Days	More than Half of the Days	Nearly Every Day
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, weight loss or overeating	0	1	2	3
6. Feeling bad about yourself or feeling that you are a failure or that you have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things like school/job related work, reading 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

Total Score: \_\_\_\_\_  
*For office use only, to be completed by physician*

10. If you checked off ANY problems, how difficult have these problems made it hard 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 _____
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*[Adapted from PHQ-9 FOR ADULTS BY Johnson JG, Harris ES, Spitzer RL, Williams JBW and the PHQ modified for adolescents PHQ-A]*