

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Your doctor has asked that you complete this questionnaire for your next visit. It collects information that may help to identify a condition or follow how well you're responding to treatment. At the time of your visit, this information will be scanned electronically and stored in your medical record.

Using a black pen, please answer ALL questions by filling in the appropriate circle(s) like ●.

Patient Information - if any of this information is incorrect, please inform the receptionist.

Patient Name: <i>(Last, First, Middle Initial)</i>	Mayo Clinic Number:	Gender:	Date of Birth:
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Date Completed: _____

Over the last **2 weeks**, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Feeling bad about yourself -- or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Thoughts that you would be better off dead or of hurting yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>add columns</i>				

(Healthcare professional: For interpretation of TOTAL, please refer to the PHQ - 9 scoring card)

TOTAL:

10. 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

Office use only -- do not mark below line

Pt. declined

