

## PHQ-9 Modified for Adolescents (PHQ-9-M)

### Instructions:

For each symptom fill in the circle beneath the answer that best describes how you have been feeling.

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.

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

<b>Year</b>	<b>Month</b>	<b>Day</b>
0 ● ○	○ ○	○ ○
1 ○	○ ○	○ ○
2 ● ○	○ ○	○ ○
3 ○	○ ○	○ ○
4 ○	○ ○	○ ○
5 ○	○ ○	○ ○
6 ○	○ ○	○ ○
7 ○	○ ○	○ ○
8 ○	○ ○	○ ○
9 ○	○ ○	○ ○

Please indicate who is completing this form:

- Patient
- Mother
- Father
- Legal Guardian
- Other

How often have you been bothered by each of the following symptoms during the past **two weeks**?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Feeling down, depressed, irritable, or hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Little interest or pleasure in doing things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Trouble falling asleep, staying asleep, or sleeping too much?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Poor appetite, weight loss, or overeating?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Feeling tired, or having little energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Trouble concentrating on things like school work, reading, or watching TV?	<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 were 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 in some way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In the <b>past year</b> have you felt depressed or sad most days, even if you felt okay sometimes? <input type="radio"/> Yes <input type="radio"/> No
If you are experiencing any of the problems on this form, how <b>difficult</b> have these problems made it for you to do your work, take care of things at home or get along with other people? <input type="radio"/> Not difficult at all <input type="radio"/> Somewhat difficult <input type="radio"/> Very difficult <input type="radio"/> Extremely difficult
Has there been a time in the <b>past month</b> when you have had serious thoughts about ending your life? <input type="radio"/> Yes <input type="radio"/> No
Have you <b>ever</b> , in your <b>whole life</b> , tried to kill yourself or made a suicide attempt? <input type="radio"/> Yes <input type="radio"/> No

\*\* If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Provider, go to a hospital emergency room or call 911.

**Office use only -- do not mark below line**

