



## DEPRESSION SCREENING (PHQ-9)

Your Answers Help Us Understand and Support Your Care

### 1 PATIENT INFORMATION

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### 2 OVER THE LAST 2 WEEKS

Mark how often each symptom has bothered you: 0 = Not at all, 1 = Several days, 2 = More than half the days, 3 = Nearly every day.

| Symptom                                                           | 0                     | 1                     | 2                     | 3                     |
|-------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Little interest or pleasure in doing things                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Feeling down, depressed, or hopeless                              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Trouble falling/staying asleep, or sleeping too much              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Feeling tired or having little energy                             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Poor appetite or overeating                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Feeling bad about yourself                                        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Trouble concentrating                                             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Moving/speaking unusually slowly or being very restless           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Thoughts that you would be better off dead or of hurting yourself | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Total Score: _____                                                |                       |                       |                       |                       |

### 3 FUNCTIONAL IMPACT

How difficult have these problems made work, home responsibilities, or relationships?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

### 4 SAFETY FOLLOW-UP

- ☐ Current thoughts of suicide
- ☐ Current plan or intent to harm yourself

If you are in immediate danger, call 911 or go to the nearest emergency department. In the U.S., call or text 988.

### 5 CLINICIAN USE

Reviewed By: \_\_\_\_\_

Date / Time: \_\_\_\_\_

Follow-up / Action: \_\_\_\_\_