

## PATIENT HEALTH QUESTIONNAIRE PHQ-9 - Nine Symptom Checklist

Patient Name: Janet Rogers (Case #1)

Date: 1/23

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

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
h. 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="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked off any problem on this questionnaire so far, 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

                                                                

3. In the past two years, have you felt depressed or sad most days, even if you felt okay sometimes?

Yes       No

**Total # Symptoms:** \_\_\_\_\_

**Total Score:** \_\_\_\_\_

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**PATIENT HEALTH QUESTIONNAIRE  
PHQ-9 - Nine Symptom Checklist**

**Basic Two Question  
Screen for Depression**

Patient Name: Janet Rogers (Case #1)

Date: 1/23

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i. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked off any problem on this questionnaire so far, 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

3. In the past two years, have you felt depressed or sad most days, even if you felt okay sometimes?  
 Yes       No

Total # Symptoms: \_\_\_\_\_

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

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**DIAGNOSTIC SYMPTOMS**  
 (Count total boxes checked in all shaded areas)  
 Enter # boxes checked as "Symptoms"

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$$(4 \times 1) + (3 \times 2) + (2 \times 3)$$

2. If you checked off any problem on this questionnaire so far, 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

3. In the past two years, have you felt depressed or sad most days, even if you felt okay sometimes?  
 Yes       No

Total # Symptoms: \_\_\_\_\_ Total Score: 16

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### **SEVERITY SCORE**

*(Multiply the boxes checked in each column by the number at the top of the column, then total all columns for the score)*