WASHINGTON
NEUROLOGY & PHYSICIANS

[PHQ-9]
PATIENT HEALTH TH QUESTIONNAIRE

First Name : _____ **Middle Initial :** _____ **Last Name :** _____

[OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS]
[use " X " to indicated your answer]

	not at all	several days	More then half the days	Nearly every day
1. Little Interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
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 or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure orhave let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV or on tablet	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite - being so figety 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	0	1	2	3

add columns _____ + _____ + _____

[HEALTHCARE PROFESSIONAL] :
[FOR INTERPRETATION OF TOTAL, PLEASE REFER TO ACCOMPANYING SCORING CARD]

TOTAL : _____

10. IF YOU CROSS 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

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