

PHQ-9 Depression Questionnaire

Member Name: _____

Date of Birth: _____ **Date of Service:** _____

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
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 or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

_____ + _____ + _____ + _____

Depression score ranges:

5-9 = mild

10-19 = moderate

≥20 = severe

PHQ-9 Score ≥ 10: likely major depression.

Total: _____

Provider's notes:

By signing below I acknowledge and confirm that I have read the information contained above in the questionnaire and notes and agree that it accurately reflects the patient's statements regarding his/her symptoms and my impressions regarding the patient.

Provider's Signature: _____ **Date:** _____