

Patient Health Questionnaire-9

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability. You do not have to answer any questions you are not comfortable answering.

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
Add columns:		+	+	
TOTAL:				

If you checked “several days” or more for some of the questions above, discuss your answers with a doctor. Also talk to your doctor if you have had thoughts of hurting yourself or thoughts that you would be better off dead. If you are thinking of harming yourself, ask for help **immediately**. Your doctor or nurse can provide help and are excellent people to tell about these kinds of thoughts.