Hamilton Family Health Team
Better care, together.

Patient Health Questionnaire for Depression (PHQ-9)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom, circle the number that best describes how you have been feeling.

		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	0	1	2	3
9	Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
	Total Score: ☐ **= Add columns:** _____ + _____ + _____				
9. a)	Has there been any time in the last 4 weeks when you have seriously thought about killing yourself? ☐ Yes ☐ No				
9. b)	Have you ever deliberately hurt yourself or made a suicide attempt? ☐ Yes ☐ No				
10	If you checked 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				