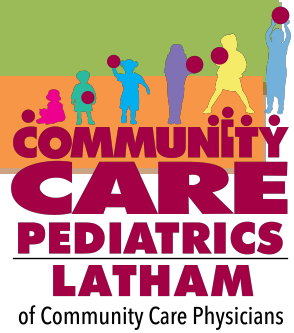


Patient Health Questionnaire (PHQ-9)

(CONFIDENTIAL, TO BE FILLED OUT BY TEEN ONLY**)**



Patient's Name: _____ Age: _____
 Today's Date: _____

*Over the past 2 weeks, how often have you been
 Bothered by any of the following problems?
 (Please circle to indicate your answer)*

	Not at all	Several Day	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. Thought that you would be better off dead, or of hurting yourself	0	1	2	3

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

****FOR OFFICE USE ONLY****

Total Colum Score: _____

1-4
Minimal

5-9
Mild

10-14
Moderate

15-19
Moderately Severe

20-27
Severe

Comments: _____

