PATIENT HEALTH QUESTIONNAIRE (PHQ-9)
Nine Symptom Depression Checklist

Patient Name: ________________________________ **Date:** _____________________

Over the **last two weeks,** how often have you been bothered by any of the following problems?

Rating	Not at all	Several days	More than half the days	Nearly every day
Score	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. 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				
i. Thoughts that you would be better off dead or of hurting yourself in some way				
Sub total score:				
Total score:				

Result:

Minimal depression	1 – 4
Mild depression	5 – 9
Moderate depression	10 – 14
Moderately severe depression	15 – 19
Severe depression	20 – 27