**PATIENT HEALTH QUESTIONNAIRE (PHQ-9)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use “x” to indicate your answer)

Not at all Several days More than half Nearly every the days day

0 1 2 3

1) Little interest or pleasure in doing things

2) Feeling down, depressed or hopeless

3)Trouble falling or staying asleep, or

sleeping too much

4) Feeling tired or having little energy

5) Poor appetite or overeating

6) Feeling bad about yourself or that you

are a failure or have let yourself or your

family down

7) Trouble concentrating on things, such as reading the newspaper or watching television

8) Moving or speaking so slowly that other people could notice. Or the opposite of being so fidgety or restless that you have been moving around a lot more than usual

9) Thoughts that you would be better off dead, or hurting yourself in some way

**Interpretation**  Minimal Depression **TOTAL SCORE:**

Mild Depression

Moderate Depression

Moderately Severe Depression

Severe Depression

**Interpretation of Total Score for Depression Severity**

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

**If your score is 5 or greater, call 830-896-4711 for an appointment and bring this questionnaire.**