



PHQ-9 Questionnaire

Name: _____ DOB: _____ MR#: _____ Date of Service: _____

We ask all our adolescent patients to complete this form at least once a year because mood can affect your health. Please ask your doctor if you have any questions.

Mood (PHQ-9)

How often have you been bothered by each of the following symptoms during the PAST 2 WEEKS?	Not at all	Several days	More than ½ the days	Nearly every day
1. Little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, irritable, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling asleep, staying asleep, or sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite, weight loss, or overeating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things like schoolwork, reading, or watching TV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3

10. In the PAST YEAR, have you felt depressed or sad most days, even if you felt okay sometimes?

Yes No

11. If you are experiencing any of the problems on this form, 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

12. Has there been a time in the PAST MONTH when you have had serious thoughts about ending your life?

Yes No

13. Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

Yes No