Patient Health Questionnaire (PHQ-9)

Patient Name: ____________________ **Date:** ____________

	Not at all	Several Days	More than half of the days	Nearly every day
Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
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 TV				
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				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
If you checked off any problem on this questionnaire so far, 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.				

Patients age 65 and older please answer the following:

Within the past 12 months		
1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO
2. Has anyone prevented you from getting food, clothes, mediation, glasses, hearing aides, or medical care, or from being with people who you wanted to be with?	YES	NO
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO
4. Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO
5. Has anyone made you afraid, touched you in ways you did not want, or hurt you physically?	YES	NO