

Patient Name: \_\_\_\_\_

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

	Not at all	Several days	More than half the days	Nearly every day
1. Over the <i>last 2 weeks</i> , how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. 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"/>
2. 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?				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### PHQ-9\* Questionnaire for Depression Scoring and Interpretation Guide For physician use only

**Scoring:**

Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all                    (#)\_\_\_\_\_ x 0= \_\_\_\_\_  
Several Days              (#)\_\_\_\_\_ x 1= \_\_\_\_\_  
More than half the days (#)\_\_\_\_\_ x 2= \_\_\_\_\_  
Nearly every day        (#)\_\_\_\_\_ x 3= \_\_\_\_\_

Total Score:                \_\_\_\_\_

Interpreting PHQ-9 Scores		Score	Actions Based on PH9 Score
Minimal depression	0-4	< 4	Action The score suggests the patient may not need depression treatment
Mild depression	5-9		Physician uses clinical judgment about treatment, based
Moderate depression	10-14	> 5 - 14	on patient's duration of symptoms and functional impairment
Moderately severe depression	15-19		
Severe depression	20-27	> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

\* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website [www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/](http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/)