

PHQ-9 REPORT

Patient: _____ Completion Date: _____

DOB: _____

Prescriber: _____

Over the last 2 weeks, have you been bothered by any of the following problems?	Not at all	Several days	More than half	Nearly every day
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| Little interest or pleasure in doing things | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Feeling down, depressed or hopeless | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Trouble falling or staying asleep, or sleeping too much | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Feeling tired or having little energy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Poor appetite or overeating | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Feeling bad about yourself or that you are a failure or have let yourself or your family down | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Trouble concentrating on things, such as reading the newspaper or watching television | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 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="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Thoughts that you would be better off dead or of hurting yourself in some way | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |