

PATIENT HEALTH QUESTIONNAIRE (PHQ-9) Modified for Teens

Name: _____ DOB: _____ Date: _____

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems? <i>(please circle or use a "✓" to indicate your answer)</i>	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor appetite or overeating?	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
8. 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?	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way?	0	1	2	3
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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
In the past year , have you felt depressed or sad most days, even if you felt OK sometimes?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has there been a time in the past month when you have had serious thoughts about ending your life?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever, in your whole life , tried to kill yourself or made a suicide attempt?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

*** Scoring by office staff: ***

Add columns (Q. 1-9): _____ + _____ + _____

Total Score: _____