



Depression Screening (PHQ-9)

PATIENT QUESTIONNAIRE

PATIENT DOB MRN DATE

Patient Health Questionnaire (PHQ-9)

Over the **last two weeks**, how often have you been bothered by any of the following problems? Check one box on each line.

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

10. If you checked off any problems, 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

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Total score 0–4 minimal · 5–9 mild · 10–14 moderate · 15–19 moderately severe · 20–27 severe

Result ☐ Negative ☐ Positive ☐ Patient declined screening ☐ Item 9 positive — addressed at visit

Follow-up ☐ None needed ☐ Advised follow-up with primary care ☐ Existing diagnosis and care plan
☐ Behavioral health referral

Notes

PROVIDER SIGNATURE

DATE

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