Patient Name _____ **Self-Evaluation Form** Patient DOB _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use a ✓ or ◯ to indicate your answer)*	**Date of Completion**	_____ / _____ / 20____		
	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 too little energy	0	1	2	3
⑤ Poor appetite or overeating	0	1	2	3
⑥ Feeling bad about yourself – maybe 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 or watching television	0	1	2	3
⑧ Moving or speaking slowly so that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot or more than usual.	0	1	2	3
⑨ Thoughts that you would be better off dead, or thoughts of hurting yourself in some way.	0	1	2	3
		+	+	
		(Total)	(Total)	(Total)
	Total Score			

⑩ If you checked any of the 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