PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: DATE:

Instructions: Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "X" to indicate your answer)

	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 YOU OR YOUR FAMILY DOWN	0	1	2	3
7. TROUBLE CONCENTRATING ON THINGS, SUCH AS READING THE NEWSPAPER OR WATCHING TV	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
COLUMN TOTAL				
TOTAL				
10. IF YOU CHECKED OFF ANY PROBLEMS, HOW DIFFICULT HAVE THESE PROBLEMS MADE IT FOR YOU TO WORK, TAKE CARE OF THINGS AT HOME, OR GET ALONG WITH OTHER PEOPLE?	_____Not difficult at all _____Somewhat difficult _____Very Difficult _____Extremely difficult			

The best telephone number to reach me at is:(_____)_____

For my prescription (CHECK one)

_____Please call it into _____

_____Please mail it to my home address

_____I will have the pharmacy call or contact your office.

PRESCRIPTIONS CAN NOT BE CALLED IN WHEN THE OFFICE IS CLOSED. CALL YOUR PHARMACY <u>DURING OUR OFFICE HOURS</u> TO MAKE SURE YOUR PRESCRIPTION IS READY.

OFFICE PHONE: 979-693-0737 OFFICE FAX: 979-693-7442