

PATIENT HEALTH QUESTIONNAIRE - 9

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Were data collected? No (provide reason in comments)

If Yes, data collected on visit date or specify date: _____
DD-Mon-YYYY

Comments:

Only the patient (subject) should enter information onto this questionnaire.

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?	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

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 0 + + +
 =Total Score:

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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I confirm this information is accurate.

Patient's/Subject's initials:

Date: