# Patient Health Questionnaire (PHQ-9)

**(**CONFIDENTIAL, TO BE FILLED OUT BY TEEN ONLY**)**

COMMUNITY CARE PEDIATRICS LATHAM
of Community Care Physicians

**Patient's Name:** _____ **Age**:_____
**Today's Date**: _____

*Over the past 2 weeks, how often have you been Bothered by any of the following problems? (Please circle to indicate your answer)*

| | Not at all | Several Day | 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.** Thought that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |

**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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***FOR OFFICE USE ONLY****

**Total Colum Score:** _____

| **1-4** | **5-9** | **10-14** | **15-19** | **20-27** |
|---|---|---|---|---|
| Minimal | Mild | Moderate | Moderately Severe | Severe |

**Comments**: _____
_____
_____
_____