



28212 Kelly Johnson Pkwy., Suite# 215, Valencia, CA 91355
16260 Ventura Blvd., Suite #700, Encino, CA 91436
P 310-895-7122 F 818-475-1433
www.brainstimcenters.com
1-888-717-1022

PATIENT HEALTH QUESTIONNAIRE FOR DEPRESSION (PHQ-9)

Patient Name: _____ DOB: _____

Number of treatments received: _____ Appointment Date: _____

OVER THE LAST 2 WEEKS HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS? PLEASE CIRCLE THE MOST ACCURATE ANSWER:

1. Little interest or pleasure in doing things?

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

1. Feeling down, depressed, or hopeless?

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

2. Trouble falling or staying asleep, or sleeping too much?

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

3. Feeling tired or having little energy?

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

4. Poor appetite or overeating?

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

5. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

6. Trouble concentrating on things, such as reading the newspaper or watching television?

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

7. 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 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

8. Thoughts that you would be better off dead or hurting yourself in some way?

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

Total Score: _____