Depression Screening Tool (PHQ-9)

Over the last **2 weeks**, how often have you been bothered by any of the following problems?

Patient Name____ Date_________________

	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? Of 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

Total of each column ______ + ______ + ______ + ______ =

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 at all difficult ◯Somewhat difficult ◯Very difficult ◯Extremely difficult

PATIENT SIGNATURE

Please note: This screening tool is only for adults. It is not a diagnostic instrument and is only to be used by you if you are 18 years or older. You are encouraged to share your results with your Best Care EAP counselor or with a physician or health care provider. Methodist Health System dba Best Care EAP, disclaims any liability, loss or risk incurred as a consequence, directly or indirectly, from the use and application of this screen.