CORVALLIS
pain management

PATIENT HEALTH QUESTIONNAIRE

PHQ-9

NAME: _____ DOB: _____ DATE: _____

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

PLEASE CIRCLE YOUR ANSWERS

	NOT AT ALL	SEVERAL DAYS	GREATER THAN HALF THE DAYS	NEARLY EVERDAY
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.	0	1	2	3
COLUMN TOTALS	_____	_____	_____	

TOTAL: _____

If you check 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 _____