Mood Disorders Centre AccEPT Primary Care Psychological Therapies Service

PATIENT HEALTH QUESTIONNAIRE (PHQ 9)

Name: _____ Number _____

Date completed; _____

Over the last two weeks, 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 have 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 the 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 of dead, or of hurting yourself in some way.**	0	1	2	**3**
	Add columns			
	Total			

10. If you have 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 _____**