

Patient Name:		Date:_			_
Over the <u>last 2 weeks</u> , been bothered by the f	following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous	s, anxious or on edge	0	1	2	3
2. Not being able	to stop or control worrying	0	1	2	3
3. Worrying too m	uch about different things	0	1	2	3
4. Trouble relaxino	9	0	1	2	3
5. Being so restle	ss that it is hard to sit still	0	1	2	3
6. Becoming easil	y annoyed or irritable	0	1	2	3
7. Feeling afraid a might happen	s if something awful	0	1	2	3
Со	lumn totals:	+ = To	+	· _ + ·	
If you checked off <u>any</u> do your work, take car Not difficult at all		e these pro along with Very ifficult	other pec	ade it for yo ple? Extremely difficult	ou to



PHQ-9

Patient Name:		Date:				
Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer"	Not all	at Several days	More than half the days	Nearly every day		
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 t much	too 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 failur or have let yourself or your family down		1	2	3		
7. Trouble concentrating on things, such as reading the newspaper or watching television	he 0	1	2	3		
8. Moving or speaking so slowly that other people of have noticed? Or the opposite — being so fidgety restless that you have been moving around a lot more tusual	or /	1	2	3		
9. Thoughts that you would be better off dead or of hurt yourself in some way	-	1	2	3		
Column totals		+ +	+			