

PATIENT HEALTH QUESTIONNAIRE- 9

PHQ-9 (For Teens)

Date:

Name:

Start Time:

Clinician:

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom, check the box beneath that answer that best describes how you have been feeling.

1. Feeling down, depressed, irritable, or hopeless?

- Not at all
- Several days
- More than half the days
- Nearly every day

2. Little interest or pleasure in doing things?

- Not at all
- Several days
- More than half the days
- Nearly every day

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

- Not at all
- Several days
- More than half the days
- Nearly every day

4. Poor appetite, weight loss, or overeating?

- Not at all
- Several days
- More than half the days
- Nearly every day

5. Feeling tired, or having little energy?

- Not at all
- Several days
- More than half the days
- Nearly every day

6. Feeling bad about yourself - or that you are a failure, or that you have let yourself or your family down?

- Not at all
- Several days
- More than half the days
- Nearly every day

7. Trouble concentrating on things like school work, reading, or watching TV?

- Not at all
- Several days
- More than half the days
- Nearly every day

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?

- Not at all
- Several days
- More than half the days
- Nearly every day

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

- Not at all
- Several days
- More than half the days
- Nearly every day

10. In the past have you felt depressed or sad most days, even if you felt okay sometimes?

- Yes
- No

11. If you are experiencing any of the problems on this form, 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 difficulty at all
- Somewhat difficulty
- Very difficulty
- Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life?

- Yes
- No

13. Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

- Yes
- No