



PHQ9P

PATIENT HEALTH QUESTIONNAIRE - 9					72883							
THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.												
Were data collected? No <input type="checkbox"/> (provide reason in comments)												
If Yes , data collected on visit date <input type="checkbox"/> or specify date: _____												
<small>DD-Mon-YYYY</small>												
<i>Comments:</i>												
Only the patient (subject) should enter information onto this questionnaire.												
Over the <u>last 2 weeks</u> , 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 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 in some way	0	1	2	3								
SCORING FOR USE BY STUDY PERSONNEL ONLY												
_____ + _____ + _____ + _____ =Total Score: _____												
<p>If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p> <table style="width: 100%; text-align: center;"> <tr> <td style="width: 25%;">Not difficult at all</td> <td style="width: 25%;">Somewhat difficult</td> <td style="width: 25%;">Very difficult</td> <td style="width: 25%;">Extremely difficult</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>					Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
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I confirm this information is accurate.	Patient's/Subject's initials:		Date:									

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