

PATIENT QUESTIONNAIRE - PHQ-9

Nine Symptom Checklist

Patient Name: _____

Date: _____

1. Over the last 2 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
	0	1	2	3
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked off any problem on this questionnaire so far, 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

Total Score : _____

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Appendix 2: Scoring of the PHQ-9

1. If there are at least 4 “checks” in the “More than half the days” or “Nearly every day” columns (including Questions #1 and #2), consider a depressive disorder. Add scores to determine severity.
2. Scoring – add up all checked boxes on PHQ-9

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

3. For every checked box:
 - Not at all = 0
 - Several days = 1
 - More than half the days = 2
 - Nearly every day = 3
4. Major Depressive Syndrome is suggested if:
 - Of the 9 items, 5 or more are checked as at least “More than half the days”
 - Either item #1 or #2 is positive, that is, at least “More than half the days”
5. Other Depressive Syndrome is suggested if:
 - Of the 9 items, 2, 3, or 4 are checked as at least “More than half the days”
 - Either item #1 or #2 is positive, that is, at least “More than half the days”
6. Also, PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally each response by the number value under the answer headings, (not at all = 0; several days = 1, more than half the days = 2, and nearly every day = 3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below:

Guide for Interpreting PHQ-9 Scores

Score	Action
≤ 4	The score suggests the patient may not need depression treatment.
$\geq 5 - 14$	Physician uses clinical judgement about treatment, based on patient's duration of symptoms and functional impairment.
≥ 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

1. Kroenke K, Spitzer RL, Williams JBW. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med.* 2001;16:606-613.
2. Williams JW Jr, Noel PH, Corders JA, Ramirez G, Pignone M. Is this patient clinically depressed? *JAMA.* 2002;287:1160-1169.