



# PATIENT HEALTH QUESTIONNAIRE – PHQ-9

Behavioral Health

Premier Community HealthCare Group, Inc.  
A Family Community Health Center



Partners Together In Healthcare

Patient Name: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

Patient Age: \_\_\_\_\_ Check One:  Single  Married  Separated  Divorced

Years Lived in Florida: \_\_\_\_\_ Check One:  African/American  Hispanic  Caucasian  Other

If not born in Florida, in which U.S. state (or country) were you born? \_\_\_\_\_

Have you ever been treated for depression (check one)?  YES  NO

Over the last two weeks, how often have you been bothered by any of the following problems?

- |  |   |
|--|---|
| <p>1. Little Interest or pleasure in doing things<br/> <input type="checkbox"/>0 Not at all<br/> <input type="checkbox"/>1 Several Days<br/> <input type="checkbox"/>2 More than half the days<br/> <input type="checkbox"/>3 Nearly every day</p> <p>2. Feeling down, depressed or hopeless<br/> <input type="checkbox"/>0 Not at all<br/> <input type="checkbox"/>1 Several Days<br/> <input type="checkbox"/>2 More than half the days<br/> <input type="checkbox"/>3 Nearly every day</p> <p>3. Trouble falling/staying asleep; sleeping too much<br/> <input type="checkbox"/>0 Not at all<br/> <input type="checkbox"/>1 Several Days<br/> <input type="checkbox"/>2 More than half the days<br/> <input type="checkbox"/>3 Nearly every day</p> <p>4. Feeling tired or having little energy<br/> <input type="checkbox"/>0 Not at all<br/> <input type="checkbox"/>1 Several Days<br/> <input type="checkbox"/>2 More than half the days<br/> <input type="checkbox"/>3 Nearly every day</p> <p>5. Poor appetite or overeating<br/> <input type="checkbox"/>0 Not at all<br/> <input type="checkbox"/>1 Several Days<br/> <input type="checkbox"/>2 More than half the days<br/> <input type="checkbox"/>3 Nearly every day</p> | <p>6. Feeling bad about yourself or that you are a failure or have let yourself or your family down<br/> <input type="checkbox"/>0 Not at all<br/> <input type="checkbox"/>1 Several Days<br/> <input type="checkbox"/>2 More than half the days<br/> <input type="checkbox"/>3 Nearly every day</p> <p>7. Trouble concentrating on things, such as reading the newspaper or watching television<br/> <input type="checkbox"/>0 Not at all<br/> <input type="checkbox"/>1 Several Days<br/> <input type="checkbox"/>2 More than half the days<br/> <input type="checkbox"/>3 Nearly every day</p> <p>8. Moving/speaking so slowly that other people could have noticed – OR – being so fidgety or restless that you've been moving around a lot more than usual.<br/> <input type="checkbox"/>0 Not at all<br/> <input type="checkbox"/>1 Several Days<br/> <input type="checkbox"/>2 More than half the days<br/> <input type="checkbox"/>3 Nearly every day</p> <p>9. Thoughts that you would be better off dead or of hurting yourself in some way.<br/> <input type="checkbox"/>0 Not at all<br/> <input type="checkbox"/>1 Several Days<br/> <input type="checkbox"/>2 More than half the days<br/> <input type="checkbox"/>3 Nearly every day</p> |
|--|---|

<p>A. If you checked off <u>any</u> problem on this questionnaire, 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 others?</p>	<input type="checkbox"/> Not Difficult At All <input type="checkbox"/> Somewhat Difficult	<input type="checkbox"/> Very Difficult <input type="checkbox"/> Extremely Difficult
<p>B. Have you been diagnosed with diabetes? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>		
<p>C. In the last 5 years, have you been a migrant or seasonal farmworker? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>		
<p>D. If Referred (<input type="checkbox"/> YES <input type="checkbox"/> NO); to whom referred? _____</p>		

Total # Symptoms: \_\_\_\_\_ Total Score: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_