PHQ-9 Pediatric Health Questionnaire

PATIENT NAME ______________________________ **DATE** ________________

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				

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

{ } Yes { } No

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

Has there been a time when you have had serious thoughts about not living?

{ } Yes { } No

Have you EVER tried to end your life or made a suicide attempt?

[ ] Yes { } No

Office use only: Severity score: __________