

Initial of Patient Last Name: \_\_\_\_\_  
 Therapist Initials: \_\_\_\_\_

Last 4 digits of SSN: \_\_\_\_\_  
 Date: \_\_\_\_\_ Session: \_\_\_\_\_

Format of CPT: Individual  Group  CPT-C  CPT

### PHQ-9

<b>Over the last 2 weeks, how often have you been bothered by any of the following problems?</b>	<i>Not at all</i>	<i>Several days</i>	<i>More than half the days</i>	<i>Nearly every day</i>
<b>Read each item carefully, and circle your response.</b>				
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 asleep, 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
<b>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?</b>				
<b>Not difficult at all</b> <input type="checkbox"/>	<b>Somewhat difficult</b> <input type="checkbox"/>	<b>Very difficult</b> <input type="checkbox"/>	<b>Extremely Difficult</b> <input type="checkbox"/>	

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