Patient Health Questionnaire (PHQ-9)

Primary Care Behavioral Health · Intake

A validated screen for depression severity. Clinician-administered or self-report.

Patient intake

1. Patient ID

PT-_____

2. Date of assessment

____ / ____ / _____

3. Age

_____

4. Sex

- ◯ Female
- ◯ Male
- ◯ Other / prefer not to say

Over the LAST 2 WEEKS, how often have you been bothered by any of the following?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
5. Little interest or pleasure in doing things	◯	◯	◯	◯
6. Feeling down, depressed, or hopeless	◯	◯	◯	◯
7. Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
8. Feeling tired or having little energy	◯	◯	◯	◯
9. Poor appetite or overeating	◯	◯	◯	◯
10. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	◯	◯	◯	◯
11. Trouble concentrating on things, such as reading or watching TV	◯	◯	◯	◯
12. Moving or speaking so slowly that others noticed — or being fidgety/restless	◯	◯	◯	◯
13. Thoughts that you would be better off dead, or of hurting yourself in some way	◯	◯	◯	◯

Functional impairment

14. If you checked off any problems, how difficult have they made it 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

Scoring: sum items 5–13 (range 0–27). 1–4 minimal, 5–9 mild, 10–14 moderate, 15–19 moderately severe, 20–27 severe. Any non-zero response to item 13 (self-harm) requires immediate clinical follow-up.