

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

### Assessment

#### PHQ2

During the past month:

1. Have you often been bothered by feeling down, depressed, or hopeless?       Yes  No
2. Have you often been bothered by little interest or pleasure in doing things?       Yes  No

If response is yes to either question please complete the additional questions below

#### PHQ9

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 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 asleep, staying asleep, or 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, feeling that you are a failure, or feeling that you 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 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. Thinking that you would be better off dead or that you want to hurt 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
0	1	2	3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>