PHQ-9 QUICK DEPRESSION ASSESSMENT

Note: Patients with suspected depression should be referred to their Primary Care Physician for appropriate management.

For initial diagnosis:
1. Patient completes PHQ-9 Quick Depression Assessment.

2. If there are at least 4 s in the two right columns (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

3.
Consider Major Depressive Disorder
• if there are at least 5 s in the two right columns (one of which corresponds to Question #1 or #2).

Consider Other Depressive Disorder
• if there are 2 to 4 s in the two right columns (one of which corresponds to Question #1 or #2).

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

Scoring—add up all checked boxes on PHQ-9
For every □**:** Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score
Total Score Depression Severity
0-4 None
5-9 Mild depression
10-14 Moderate depression
15-19 Moderately severe depression
20-27 Severe depression

PHQ9P

PATIENT HEALTH QUESTIONNAIRE-9

72883

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Were data collected? **No** ☐ *(provide reason in comments)*

If **Yes**, data collected on visit date ☐ **or** specify date: _____
DD-Mon-YYYY

Comments:

Only the patient (subject) should enter information onto this questionnaire.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
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 or 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

SCORING FOR USE BY STUDY PERSONNEL ONLY

0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

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I confirm this information is accurate.	Patient's/Subject's initials:	Date: