



PHQ9P

PATIENT HEALTH QUESTIONNAIRE - 9					72883							
THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.												
Were data collected? No <input type="checkbox"/> (provide reason in comments)												
If Yes , data collected on visit date <input type="checkbox"/> or specify date: _____ DD-Mon-YYYY												
Comments:												
Only the patient (subject) should enter information onto this questionnaire.												
Over the <u>last 2 weeks</u> , 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 _____ + _____ + _____ + _____ =Total Score: _____												
<p>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?</p> <table style="width: 100%; text-align: center;"> <tr> <td style="width: 25%;">Not difficult at all</td> <td style="width: 25%;">Somewhat difficult</td> <td style="width: 25%;">Very difficult</td> <td style="width: 25%;">Extremely difficult</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>					Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. Copyright © 2005 Pfizer, Inc. All rights reserved. Reproduced with permission. EPI0905.PHQ9P												
I confirm this information is accurate.	Patient's/Subject's initials:	Date:										

Copyright © Pfizer Inc. All rights reserved. Reproduced with permission.



American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of Bright Futures Tool and Resource Kit. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.