



DATE OF VISIT: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

PATIENT HEALTH QUESTIONNAIRE 9 (PHQ-9)

Over the past 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.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2.	Feeling down, depressed or hopeless.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3.	Trouble falling asleep, staying asleep, or sleeping too much.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4.	Feeling tired or having little energy.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5.	Poor appetite or overeating.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6.	Feeling bad about yourself, or that you're a failure or have let yourself & your family down.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7.	Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9.	Thoughts that you would be better off dead, or of hurting yourself in some way.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
		Column Totals:			
		Add Column Totals Together:			

If you checked off any problems above...

10. How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

- Not At All Somewhat Difficult Very Difficult Extremely Difficult

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11. How often do you have a drink containing alcohol?

- Never Monthly or less 2-4 times per month 2-3 times per week 4+ times per week

12. How many standard drinks containing alcohol do you have on a typical day?

- 0, 1, or 2 3 or 4 5 or 6 7 to 9 10 or more

13. How often do you have six or more drinks on one occasion?

- Never Less than monthly Monthly Weekly Daily or almost daily

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