



**PATIENT HEALTH  
QUESTIONNAIRE (PHQ-9)**

**MetroHealth of  
Downtown Orlando**  
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Orlando, FL 32806  
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Patient Name: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

**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
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

**Column Totals**  +  +

**TOTAL**

**If you checked off any problems, 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 difficult at all     
  Somewhat difficult     
  Very difficult     
  Extremely difficult

Total Score	Depression Severity	Total Score	Depression Severity
1-4	Minimal depression	15-19	Moderately severe depression
5-9	Mild depression	20-27	Severe depression
10-14	Moderate depression		