



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

**MetroHealth of
Ormond Beach**
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Ormond Beach, FL 32174
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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		

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