PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please CIRCLE your answer	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 or 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 are 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

If you have circled 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
☐	☐	☐	☐

PHQ 9 Questionnaire for Depression Scoring and Interpretation Guide Scoring:
Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0 - 27

Not at all (#) _____ x 0 = _____

Several days (#) _____ x 1 = _____

More than half the days (#) _____ x 2 = _____ Total score: _____

Nearly every day (#) _____ x 3 = _____

Interpreting PHQ 9 Scores

Diagnosis	**Total Score**	**For Score**	**Action**
Minimal depression	0-4	≤ 4	No treatment
Mild depression	5-9		
Moderate depression	10-14	5 - 14	Clinical judgment for treatment
Moderately severe depression	15-19		
Severe depression	20-27	> 14	Treatment needed

PHQ-4 Short Screen

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Pleas circle your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

<u>Scoring</u>

PHQ-4 total score ranges from 0 to 12, with categories of psychological distress
- None 0-2
- Mild 3-5
- Moderate 6-8
- Severe 9-12

Anxiety subscale = sum of items 1 and 2 (score ≥ 3 is positive for anxiety)
Depression subscale = sum of items 3 and 4 (score ≥ 3 is positive for depression)