

PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name _____ Age _____ Sex: Female Male Today's Date _____

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain in your arms, legs, or joints (knees, hips, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Menstrual cramps or other problems with your periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Over the last 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
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.
 Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).
 Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).