ADULT PATIENT HEALTH QUESTIONNAIRE – PHQ 2		Patient Name:	DOB:	
How often have you been be	othered by the below symptoms over the last tw	o weeks?		
Little Interest, Pleasure in Activities		Feeling Down, Depr	Feeling Down, Depressed, Hopeless	
Not at all	More than half the days	☐ Not at all	More than half the days	
Several days	Nearly every day	Several days	Nearly every day	
For a score of 1 to 6, complete the remaining questions.				
The q	uestions above are the first step of the PHQ-9, fo	or a score of 0 no additional evaluation is	s needed at this time.	
	H QUESTIONNAIRE – PHQ 9			
Trouble Falling or Sta	aying Asleep 	Feeling Tired or Littl	e Energy	
Not at all	More than half the days	Not at all	More than half the days	
Several days	Nearly every day	Several days	Nearly every day	
Poor Appetite or Overeating		Feeling Bad About Y	Feeling Bad About Yourself	
Not at all	More than half the days	☐ Not at all	More than half the days	
Several days	Nearly every day	Several days	Nearly every day	
Trouble Concentrating		Moving or Speaking	Moving or Speaking Slowly	
Not at all	More than half the days	Not at all	More than half the days	
Several days	Nearly every day	Several days	Nearly every day	
Thoughts Better Off Dead or Hurting Self		Difficulty at Work, H	Difficulty at Work, Home, or Getting Along With Others	
Not at all	More than half the days	☐ Not at all	More than half the days	
Several days	Nearly every day	Several days	Nearly every day	
If response anything but "No	ot at all" notify attending physican.			
With In One Year Post Partum		Depression Screen I	Depression Screen Interpretation	
Yes	No	Negative	Positive	
Comment				