PHQ-9

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale to make your choice.

Over the last two weeks, how often were bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling badly about yourself, or that you are a failure, or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading or watching TV	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you have moved around much more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Interpretation

This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories. PHQ-9 total score for the nine items ranges from 0 to 27. Scores of 5, 10, 15, and 20 represent cut points for mild, moderate, moderately severe and severe depression, respectively.

References

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine*, *16*(9), 606–613.

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