**Patient Health Questionnaire-9** (PHQ-9)

| **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*** |
| --- | --- | --- | --- | --- |
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | *3* |
| 1. Feeling down, depressed, or hopeless | 0 | 1 | 2 | *3* |
| 1. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | *3* |
| 1. Feeling tired or having little energy | 0 | 1 | 2 | *3* |
| 1. Poor appetite or overeating | 0 | 1 | 2 | *3* |
| 1. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | *3* |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | *3* |
| 1. 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* |
| 1. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | *3* |

*For office coding: \_­­­\_\_\_\_\_0 + + +*

*= Total Score*

**If you checked off 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**  **🞎** |
| --- | --- | --- | --- |

*\* This question is not scored*

**Cuestionario sobre la salud del paciente-9** (PHQ-9)

| **Durante las *últimas 2 semanas,* ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?** | **Ningún día** | **Varios días** | **Más de la mitad de los días** | **Casi todos los días** |
| --- | --- | --- | --- | --- |
| 1. Poco interés o placer en hacer cosas | 0 | 1 | 2 | 3 |
| 1. Se ha sentido decaído(a), deprimido(a) o sin esperanzas | 0 | 1 | 2 | 3 |
| 1. Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado | 0 | 1 | 2 | 3 |
| 1. Se ha sentido cansado(a) o con poca energía | 0 | 1 | 2 | 3 |
| 1. Sin apetito o ha comido en exceso | 0 | 1 | 2 | 3 |
| 1. Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia | 0 | 1 | 2 | 3 |
| 1. Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión | 0 | 1 | 2 | 3 |
| 1. ¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal | 0 | 1 | 2 | 3 |
| 1. Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera | 0 | 1 | 2 | 3 |

*For office coding: \_\_\_\_0 + + +*

*= Total Score*

**Si marcó *cualquiera* de los problemas, ¿qué tanta *dificultad* le han dado estos problemas para hacer su trabajo, encargarse de las tareas del hogar, o llevarse bien con otras personas?**

| No ha sido  difícil  🞎 | Un poco  difícil  🞎 | Muy  difícil  🞎 | Extremadamente difícil  🞎 |
| --- | --- | --- | --- |

# PHQ-9 Scores and Proposed Treatment Actions\*

| Score | Severity | Proposed Treatment Actions |
| --- | --- | --- |
| 0-4 | None-minimal | None |
| 5-9 | Mild | Watchful waiting; repeat PHQ-9 at follow-up |
| 10-14 | Moderate | Treatment plan, considering counseling, follow-up and/or pharmacotherapy |
| 15-19 | Moderately Severe | Active treatment with pharmacotherapy and/or psychotherapy |
| 20-27 | Severe | Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management |

\* From Kroenke K, Spitzer RL, Psychiatric Annals 2002;32:509-521

**Patient Health Questionnaire-2** (PHQ-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** |
| --- | --- | --- | --- | --- |
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

*For office coding: \_\_\_­­\_\_\_0 + + +*

*= Total Score*

**Cuestionario sobre la salud del paciente-2** (PHQ-2)

| **Durante las *últimas 2 semanas*, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?** | **Ningún día** | **Varios días** | **Más de la mitad de los días** | **Casi todos los días** |
| --- | --- | --- | --- | --- |
| 1. Poco interés o placer en hacer cosas | 0 | 1 | 2 | 3 |
| 1. Se ha sentido decaído(a), deprimido(a) o sin esperanzas | 0 | 1 | 2 | 3 |

*For office coding: ­­­\_­­\_\_\_\_\_0 + + +*

*= Total Score*

# PHQ-2 Scores and Recommended Actions

The PHQ-2 consists of the first 2 questions of the PHQ-9. Scores range from 0 to 6. The recommended cut point is a score of 3 or greater. Recommended actions for persons scoring 3 or higher are one of the following:

* Administer the full PHQ-9
* Conduct a clinical interview to assess for Major Depressive Disorder

1. Korenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. *Med Care*. 2003, Nov;41(11):1284-92.
2. Kroenke K(1), Spitzer RL, Williams JB, Löwe B. The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: a systematic review. *Gen Hosp Psychiatry*. 2010 Jul-Aug;32(4):345-59.

**Patient Health Questionnaire-9  
Modified for Teens**

| **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** |
| --- | --- | --- | --- | --- |
| 1. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed, irritable or hopeless? | 0 | 1 | 2 | 3 |
| 1. Trouble falling asleep, or staying asleep, or sleeping too much? | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy? | 0 | 1 | 2 | 3 |
| 1. Poor appetite, weight loss, or overeating? | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things like school work, reading, or watching TV? | 0 | 1 | 2 | 3 |
| 1. 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 |
| 1. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

*For office coding: \_­­­\_\_\_\_\_0 + + +*

*= Total Score*

| 1. If you are experiencing any of the problems on this form, 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  🞎 |
| --- | --- | --- | --- | --- |
| 1. In the ***past year***, have you felt depressed or sad most days, even if you felt OK sometimes? | Yes  🞎 | No  🞎 |  |  |
| 1. Has there been a time in the ***past month*** when you have had serious thoughts about ending your life? | Yes  🞎 | No  🞎 |  |  |
| 1. Have you ***ever, in your whole life***, tried to kill yourself or made a suicide attempt? | Yes  🞎 | No  🞎 |  |  |

**Una encuesta de parte de su proveedor de cuidados de salud - PHQ-9 modificado para adolescentes**

| **¿Qué tan a menudo ha sentido cada uno de los siguientes síntomas durante las dos ultimas semanas? Por cada síntoma escriba una “X” en el cuadro que mehor describe como se siente.** | **(0)**  **Ninguno** | **(1)**  **Varios**  **Días** | **(2)**  **Mas de la Mitad**  **de los Días** | **(3)**  **Casi Todos**  **los Días** |
| --- | --- | --- | --- | --- |
| 1. ¿Se seinte deprimido, irritado, o sin esperanza? | 0 | 1 | 2 | 3 |
| 1. ¿Poco interés or placer para hacer cosas? | 0 | 1 | 2 | 3 |
| 1. ¿Tiene dificultad para dormirse, quedarse dormido, o duerme demasiado? | 0 | 1 | 2 | 3 |
| 1. ¿Poco apetito, perdida de peso, o come demasiado? | 0 | 1 | 2 | 3 |
| 1. ¿Se siente cansado o tiene poca energía? | 0 | 1 | 2 | 3 |
| 1. ¿Se seinte mal por usted mismo-o siente que es un fracasado, o que le ha fallado a su familia y a usted mismo? | 0 | 1 | 2 | 3 |
| 1. ¿Tiene problema para concetrarse en cosas tales como tareas escolares, leer, o ver televisión? | 0 | 1 | 2 | 3 |
| 1. ¿Se mueve o habla tan lentamente que las otras personas pueden notarlo?   ¿O al contrario-esta tan inquieto que se mueve mas de lo usual? | 0 | 1 | 2 | 3 |
| 1. ¿Pensamientos que estaría mejor muerto o de hacerse daño usted mismo de alguna manera ? | 0 | 1 | 2 | 3 |

*Para la codificación de oficina: \_­­­\_\_\_\_\_0 + + +*

*= Puntaje total*

| 1. ¿En el año pasado se ha sentido deprimido o triste la mayoría de los días, aun cuando se siente bien algunas veces? | Si 🞎 | No 🞎 |  |  |
| --- | --- | --- | --- | --- |
| 1. Si usted esta pasando por cualquiera de los problemas mencionados en este formulario, ¿qué tan difícil estos problemas le causan para hacer su trabajo, hacer las cosas de la casa, o relacionarse con las demás personas? | No difícil  🞎 | Un poco difícil  🞎 | Muy  difícil  🞎 | Sumamente  difícil  🞎 |
| 1. ¿En el mes pasado hubo algún momento donde usted pensó seriamente en terminar con su vida? | Si  🞎 | No  🞎 |  |  |
| 1. ¿Alguna vez en su vida, trato de matarse o trato de suicidarse? | Si  🞎 | No  🞎 |  |  |

**Scoring the PHQ-9 modified for Teens**

Scoring the PHQ-9 modified for teens is easy but involves thinking about several different aspects of depression.

**To use the PHQ-9 as a diagnostic aid for Major Depressive Disorder:**

* Questions 1 and/or 2 need to be endorsed as a “2” or “3”
* Need five or more positive symptoms (positive is defined by a “2” or “3” in questions 1-8 and by a “1”, “2”, or “3” in question 9).
* The functional impairment question (How difficult....) needs to be rated at least as “somewhat difficult.”

**To use the PHQ-9 to screen for all types of depression or other mental illness:**

* All positive answers (positive is defined by a “2” or “3” in questions 1-8 and by a “1”, “2”, or “3” in question 9) should be followed up by interview.
* A total PHQ-9 score > 10 (see below for instructions on how to obtain a total score) has a good sensitivity and specificity for MDD.

**To use the PHQ-9 to aid in the diagnosis of dysthymia:**

* The dysthymia question (In the past year...) should be endorsed as “yes.”

**To use the PHQ-9 to screen for suicide risk:**

* All positive answers to question 9 as well as the two additional suicide items MUST be followed up by a clinical interview.

**To use the PHQ-9 to obtain a total score and assess depressive severity:**

* Add up the numbers endorsed for questions 1-9 and obtain a total score. See table below for score interpretations.

| Score | Severity |
| --- | --- |
| 0-4 | None-minimal |
| 5-9 | Mild |
| 10-14 | Moderate |
| 15-19 | Moderately Severe |
| 20-27 | Severe |