*Do not write, stamp, punch holes or affix a sticker in this area.*

Direction of Feed

# CHI PHQ-9

Please answer every question

*To reproduce, follow the printing instructions. Do not fold this form.*

## Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

## Over the past 2 weeks, how often have you been 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 | ⬭ | ⬭ | ⬭ | ⬭ |
| 2. Feeling down, depressed or hopeless | ⬭ | ⬭ | ⬭ | ⬭ |
| 3. Trouble falling or staying asleep, or sleeping too much | ⬭ | ⬭ | ⬭ | ⬭ |
| 4. Feeling tired or having little energy | ⬭ | ⬭ | ⬭ | ⬭ |
| 5. Poor appetite or overeating | ⬭ | ⬭ | ⬭ | ⬭ |
| 6. Feeling bad about yourself, or feel like a failure, or have let yourself or your family down | ⬭ | ⬭ | ⬭ | ⬭ |
| 7. Trouble concentrating on things, such as reading the paper or watching TV | ⬭ | ⬭ | ⬭ | ⬭ |
| 8. Moving or speaking slowly or being fidgety | ⬭ | ⬭ | ⬭ | ⬭ |
| 9. Thoughts that you would be better dead or of hurting yourself | ⬭ | ⬭ | ⬭ | ⬭ |

## How difficult have these problems made it for you to do your work, take care of things at home, or get along with people?

- ⬭ Not difficult at all
- ⬭ Somewhat difficult
- ⬭ Very difficult
- ⬭ Extremely difficult