

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

Direction of Feed

Patient Health Questionnaire (PHQ)-2

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

Please answer every question

Marking Instructions

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



PLEASE PRINT PATIENT'S LAST NAME

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PLEASE PRINT PATIENT'S FIRST NAME

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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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Feeling down, depressed or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>