BrainStim CENTERS

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PATIENT HEALTH QUESTIONNAIRE FOR DEPRESSION (PHQ-9)

Patient Name: _____ DOB: _____

Number of treatments received: _____ Appointment Date:_____

OVER THE LAST 2 WEEKS HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS? PLEASE CIRCLE THE MOST ACCURATE ANSWER:

1. **Little interest or pleasure in doing things?**

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

2. **Feeling down, depressed, or hopeless?**

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

3. **Trouble falling or staying asleep, or sleeping too much?**

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

4. **Feeling tired or having little energy?**

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

5. **Poor appetite or overeating?**

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

6. **Feeling bad about yourself—or that you are a failure or have let yourself or your family down?**

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

7. **Trouble concentrating on things, such as reading the newspaper or watching television?**

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

8. **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 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

9. **Thoughts that you would be better off dead or hurting yourself in some way?**

0 Not at all 1 Several days 2 More than half the days 3 Nearly everyday

Total Score: _____