☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9) ADOLESCENTS

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (*Please circle your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling down, depressed, irritable, or hopeless	0	1	2	3
2. Little interest or pleasure in doing things	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Poor appetite, weight loss, or overeating	0	1	2	3
5. Feeling tired, or having little energy	0	1	2	3
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or family down	0	1	2	3
7. Trouble concentrating on things like school work, 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 been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	0 +	+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).			TOTAL:	

In the <u>past year</u> have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

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

Has then been a time in the <u>past month</u> when you have had serious thoughts about ending your life?

☐ Yes ☐ No

Have you <u>EVER</u>, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐ Yes ☐ No

Patient Signature: _____ Date: _____ Time: _____

Staff Signature: _____ Date: _____ Time: _____

QUESTIONNAIRE

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[2050]

PATIENT LABEL