PHQ-9 for ADOLESCENTS
Modified Patient Health Questionnaire

Name: _____Date:_____

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? (Please **CIRCLE** to indicate your answer)	**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
2. Feeling down, depressed, irritable, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite, weight loss, or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as school work, reading or watching television	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 in some way	0	1	2	3

Note: Clinic Staff - Please file electronically in the EpicCare PHQ9A Document Flow sheet.

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc.

PE2701002-01-17

Rev. Date 2014155

Additional Depression Questions for Adolescents

Name: _____Date:_____

Instructions: This questionnaire will help us understand how you have been feeling. The results will help you and your doctor follow your progress.

Patient Questionnaire (Please **CIRCLE** to indicate your answer.)					Y, N or N/A
1. Have your symptoms of depression lasted longer than two years?				Y	N N/A
2. Have you had similar symptoms lasting at least two weeks in the past? If yes, how many times?				Y	N N/A
3. Have you had counseling in the past for depression?				Y	N N/A
4. If you have you taken medications for depression in the past, did they help?				Y	N N/A
5. If you have taken medications for depression in the past, did you have a problem with any medication?				Y	N N/A
6. Have you ever made plans to harm or kill yourself?				Y	N N/A
7. Has any family member attempted or committed suicide?				Y	N N/A
8. At any point in your life, have you gone through periods when you felt the opposite of being depressed—very "high" or "speeded up," with lots of energy? Didn't need sleep? Felt you could do anything? Circle "yes" if you had these symptoms and they lasted at least a few days and caused trouble for you in your life.				Y	N N/A
9. In the past two weeks, have you heard or seen things that other people couldn't see or hear that might really not be there?				Y	N N/A
10. Has anyone ever hit you or touched you in a way that made you uncomfortable or afraid?				Y	N N/A
11. Have you recently experienced the death of a close friend or family member?				Y	N N/A
12. Are you having difficulty with school work?				Y	N N/A
13. Are you having trouble with fighting or any kind of bullying?				Y	N N/A
14. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?				Y	N N/A
15. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?				Y	N N/A
16. Do you ever use alcohol or drugs while you are by yourself, alone?				Y	N N/A
17. Do your family or friends ever tell you that you should cut down on your drinking or drug use?				Y	N N/A
18. Do you ever forget things you did while using alcohol or drugs?				Y	N N/A
19. Have you gotten into trouble while you were using alcohol or drugs?				Y	N N/A
20. Over the last two weeks, how often have you been bothered by the following problems:	Not at all [0]	Several days [1]	Over half the days [2]		Nearly every day [3]
• Feeling nervous, anxious, or on edge?	Not at all [0]	Several days [1]	Over half the days [2]		Nearly every day [3]
• Not being able to stop or control worrying?					

Clinic Staff - Please file electronically in the EpicCare PHQ9-A Document Flow sheet

Rev. Date 2014155