Patient Health Questionnaire (PHQ-9)

Depression screening form with scoring and interpretation guide

Name _____ Date completed _____

Date of birth _____ Record / MRN number _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Check one box for each problem.

	Problem	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
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 that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9	Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

If you checked off any problems, 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

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Total score (items 1 to 9, range 0 to 27) _____ Severity band _____

Item 9 answered above 0? Yes / No _____ Action taken, completed by and date _____

Scoring and interpretation guide

For the clinician reviewing the completed form

How to score

1. Score each item from 0 (not at all) to 3 (nearly every day).
2. Add items 1 to 9 for a total between 0 and 27.
3. Check item 9 separately. Any answer above 0 needs a direct conversation and a documented risk review, whatever the total.
4. Record the difficulty question beside the score. It is not part of the total.

Severity bands

Total score	Severity band	Typical clinical focus
0 to 4	Minimal	Routine monitoring, and review if symptoms change
5 to 9	Mild	Watchful waiting and re-check; discuss support options
10 to 14	Moderate	Discuss treatment options; consider counseling or further assessment
15 to 19	Moderately severe	Prompt clinical review; consider active treatment planning
20 to 27	Severe	Urgent clinical review; consider active treatment and safety planning

A total of 10 or more is the usual cutoff for flagging likely major depression. The PHQ-9 is a screener, not a diagnosis, so use it to support clinical judgment.

Score log

Date	Reason	Total	Band	Item 9 > 0	Action taken	Change from baseline

A change of 5 points from baseline is commonly treated as clinically meaningful. Confirm against your local guidance.

The PHQ-9 was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. Instrument and terms of use: phqscreeners.com. Bands and cutoff: Kroenke, Spitzer and Williams, 2001. Form layout and guide by Pabau.