

## Depression Screen

For each of these items, check the box that best describes your behavior. Please complete this as if it were your WORST day!

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date: \_\_\_\_\_

	In the past two weeks:	Not at all	Several days	More than ½ the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed 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 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 reading the newspaper 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	0	1	2	3
	PHQ-9 Total:				
10	If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home or get along with people?	0	1	2	3