

# Patient Health Questionnaire: modified for Adolescents

Name: \_\_\_\_\_ Clinician: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:** How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

|   | (0)<br>Not At All | (1)<br>Several<br>Days | (2)<br>More Than<br>Half the<br>Days | (3)<br>Nearly<br>Every Day |
|---|-------------------|------------------------|--------------------------------------|----------------------------|
| 1. Feeling down, depressed, irritable, or hopeless?   |                   |                        |                                      |                            |
| 2. Little interest or pleasure in doing things?   |                   |                        |                                      |                            |
| 3. Trouble falling asleep, staying asleep, or sleeping too much?  |                   |                        |                                      |                            |
| 4. Poor appetite, weight loss, or overeating?   |                   |                        |                                      |                            |
| 5. Feeling tired, or having little energy?  |                   |                        |                                      |                            |
| 6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?   |                   |                        |                                      |                            |
| 7. Trouble concentrating on things like school work, reading, or watching TV?   |                   |                        |                                      |                            |
| 8. Moving or speaking so slowly that other people could have noticed?<br><br>Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?  |                   |                        |                                      |                            |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way? <i>al.</i>   |                   |                        |                                      |                            |
| In the <b>past year</b> have you felt depressed or sad most days, even if you felt okay sometimes?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                   |                        |                                      |                            |
| If you are experiencing any of the problems on this form, how <b>difficult</b> have these problems made it for you to do your work, take care of things at home or get along with other people?<br><br><input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult |                   |                        |                                      |                            |
| Has there been a time in the <b>past month</b> when you have had serious thoughts about ending your life?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                   |                        |                                      |                            |
| Have you <b>EVER</b> , in your <b>WHOLE LIFE</b> , tried to kill yourself or made a suicide attempt?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                   |                        |                                      |                            |

*\*\*If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

**Office use only:      Severity score: \_\_\_\_\_**

Modified with permission from the PHQ-9 [Modified from PRIME-MD PHQ-9 ©. Copyright© 1999 Pfizer Inc. (Spitzer et al, JAMA, 1999)], Revised PHQ-A (Johnson, 2002), and the Columbia DDS (DISC Development Group, 2000)

## Scoring the PHQ-9 modified

Only questions 1-9 count in the scoring, but the other questions must be looked at to assess dysthymia and suicidality.

Add up all "X"ed boxes on the PHQ-9.

**For every X:**

- Not at all = 0
- Several days = 1
- More than half the days = 2
- Nearly every day = 3

| <b>Total Score</b> | <b>Depression Severity</b>   |
|--------------------|------------------------------|
| 1-4                | Minimal depression           |
| 5-9                | Mild depression              |
| 10-14              | Moderate depression          |
| 15-19              | Moderately severe depression |
| 20-27              | Severe depression            |