PARK WEST
FAMILY MEDICINE

PATIENT HEALTH QUESTIONNAIRE

Patient name _____ Date _____

Over the last TWO WEEKS, how often have you been bothered by any of the following problems?
(Use a ✔"to mark the square that corresponds with your answer)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
Feeling down, depressed or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
Trouble falling or staying asleep, or sleeping too long	0 ☐	1 ☐	2 ☐	3 ☐
Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
Feeling bad about yourself, or that you're a failure, or have let yourself or family down	0 ☐	1 ☐	2 ☐	3 ☐
Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
Moving or speaking so slowly that other people have noticed. Or the opposite: being so fidgety or restless that you've been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
Thoughts that you would be better off dead, or thoughts of hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐

Add columns _____ + _____ + _____ + _____

TOTAL _____

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
If you checked off any problems above, how difficult have these problems made it for you to work, take care of things at home or get along with other people?	☐	☐	☐	☐

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