The TMS Center of New Jersey

55 North Gilbert Street Suite 2203
Tinton Falls, New Jersey 07701

(732) 740-7675 Telephone
(732) 842-0100 Fax
www.thetmscenterofnj.com

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ AGE:_____ DATE:_____

Over the last 2 *weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	0 Not at all	1 - 2 Several days	3 - 4 More than half the days	16+ > 5 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 figety 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
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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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