SunCountry HEALTH REGION

PHQ-9 for ADOLESCENTS
Modified Patient Health Questionnaire

NAME: _____ **DATE:** _____

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest in doing things	0	1	2	3
2. Feeling down, depressed, irritable or hopeless	0	1	2	3
STOP *If you checked "more than half the days" or "nearly everyday" for at least **ONE** of the above questions, please complete the following questions.*				
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, weight loss 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 school work, reading 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 hurting yourself in some way	0	1	2	3

Add columns ☐ + ☐ + ☐

Total ☐

Assess Suicide risk if a score of 1, 2 or 3 is recorded on Question 9 or a total score of 10 or greater. Suicide Risk Assessment form is MH-Gen-004 located at: R:\Forms\MH-MentalHealth\Gen on the R:Drive.

SCHR Mental Health Intake: 1-800-216-7689 (service available 24 hours a day)