Patient Health Questionnaire (PHQ) 9

Source: The items are from the 9-item PHQ-9. Public Domain

Reference: Kroenke K., Spitzer R.L., & Williams J.B. (2001). The PHQ-9: validity of a brief depression severity measure. *J. of Gen Intern Med*, 16, 606-613

http://www.ncbi.nlm.nih.gov/pubmed/11556941

Scale Description: The scale is the 9-item subset of the Patient Health Questionnaire asking about symptoms of major depression. Developed by Pfizer, Inc.

Scoring and Algorithm

Note: For each assessment, there is an algorithm leading to one of three acuity ranges: Low, Moderate, or High. The logic for the user receiveing specific feedback is included in the algorithms below.

Each items has scoring options from 0 – 3
Not at all = 0
Several days = 1
More than half the days = 2
Nearly every day = 3

For those users who complete all 9 items, the total score is the sum of those items, possible range 0-27.

Algorithm

Anyone who endorses Question #9 (Self Harm) greater than 0 should be followed up immediately.

If Total score falls in range 0-4 Low Acuity

If Total score falls in range 5-15 Moderate Acuity

If Total score falls in range 16-27 High Acuity

DEPRESSION ASSESSMENT

1. Over the last two weeks, how often have you been bothered by having little interest or pleasure in doing things?

Not at all	Several days	More than half the days	Nearly every day

2. Over the last two weeks, how often have you been bothered by feeling down, depressed or hopeless?

Not at all	Several days	More than half the days	Nearly every day

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 every day
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 in some way.	0	1	2	3