

Initial of Patient Last Name: _____
 Therapist Initials: _____

Last 4 digits of SSN: _____
 Date: _____ Session: _____

Format of CPT: Individual Group CPT-C CPT

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.	<i>Not at all</i>	<i>Several days</i>	<i>More than half the days</i>	<i>Nearly every day</i>
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 asleep, 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
If you checked off <u>any</u> problems, how <u>difficult</u> 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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely Difficult <input type="checkbox"/>	

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