KEYSTONE ADVANCED THERAPIES

PHQ-9 FORM

1. Little Interest or pleasure in doing things?
   - 0 - Not at all
   - 1 - Several days
   - 2 - More than half the days
   - 3 - Nearly every day

2. Feeling down, depressed, or hopeless?
   - 0 - Not at all
   - 1 - Several days
   - 2 - More than half the days
   - 3 - Nearly every day

3. Trouble falling asleep, staying asleep, or sleeping too much?
   - 0 - Not at all
   - 1 - Several days
   - 2 - More than half the days
   - 3 - Nearly every day

4. Feeling tired or having little energy?
   - 0 - Not at all
   - 1 - Several days
   - 2 - More than half the days
   - 3 - Nearly every day

5. Poor appetite or overeating?
   - 0 - Not at all
   - 1 - Several days
   - 2 - More than half the days
   - 3 - Nearly every day

6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down?

0 - Not at all
1 - Several days
2 - More than half the days
3 - Nearly every day

7. Trouble concentrating on things, such as reading or watching television?

0 - Not at all
1 - Several days
2 - More than half the days
3 - Nearly every day

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 - Not at all
1 - Several days
2 - More than half the days
3 - Nearly every day

9. Thoughts that you would be better off dead, or hurting yourself in some other way?

0 - Not at all
1 - Several days
2 - More than half the days
3 - Nearly every day

Score total: _____

Name: _____

Date: _____

Reviewed: yes or no

Technician signature: _____