Annu H. Navani, M.D., Q.M.E. & Associates
Board Certified in Pain Management & Anesthesia
COMPREHENSIVE
Pain Management Center
Defining Excellence in Pain Management
Ph: 408.356.5292
Fax: 408.356.5307
www.cpainmc.com

PHQ-9 – Nine Symptom Checklist

Patient Name _____ **Date** _____

1. 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.
   a. Little interest or pleasure in doing things:
      Not at all **Several days** **More than half the days** **Nearly every day**
   b. Feeling down, depressed or hopeless
      Not at all **Several days** **More than half the days** **Nearly every day**
   c. Trouble falling asleep, staying asleep, or sleeping too much
      Not at all **Several days** **More than half the days** **Nearly every day**
   d. Feeling tired or having little energy
      Not at all **Several days** **More than half the days** **Nearly every day**
   e. Poor appetite or overeating
      Not at all **Several days** **More than half the days** **Nearly every day**
   f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself your family down
      Not at all **Several days** **More than half the days** **Nearly every day**
   g. Trouble concentrating on things such as reading a newspaper or watching television
      Not at all **Several days** **More than half the days** **Nearly every day**
   h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
      Not at all **Several days** **More than half the days** **Nearly every day**
   i. Thinking that you would be better off dead or that you want to hurt yourself in some way
      Not at all **Several days** **More than half the days** **Nearly every day**

2. If you checked off any problem on this questionnaire so far, 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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PHQ-9 – Scoring Tally Sheet

Patient Name _____ **Date** _____

1. 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.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, stay asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
TOTALS				

2. If you checked off any problem on this questionnaire so far, 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
0	1	2	3

TOTAL: _____

2577 Samaritan Dr. Suite 705 San Jose, CA 95124