PHQ-9: Modified for Teens

Name: ______ Date: _____

	Instructions: How often have you been bothered by past two weeks ? For each symptom put an "X" in t describes how you have been feeling.	he box beneath	the answer t	hat best	
		Not At All	Several Days	More Than Half the Days	Nearly Every Day
	Feeling down, depressed, irritable, or hopeless?				
2.	Little interest or pleasure in doing things?				
3.	Trouble falling asleep, staying asleep, or sleeping too much?				
4.	Poor appetite, weight loss, or overeating?				
5.	Feeling tired, or having little energy?				
6.	Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7.	Trouble concentrating on things like school work, reading, or watching TV?				
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?				
In t	he <u>past year</u> have you felt depressed or sad most days, [] Yes [] No	even if you felt	okay sometir	nes?	
If you are experiencing any of the problems on this form, 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					
Has there been a time in the <u>past month</u> when you have had serious thoughts about ending your life? [] Yes [] No					
Have you EVER , in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? [] Yes [] No					
	**If you have had thoughts that you would be bette please discuss this with your Health Care Clinician,				

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Office use only: Severity score: _____