

Patient Health Questionnaire — Modified for Teens

Name:

Date:

Over the last 2 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
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, irritable or hopeless?	0	1	2	3
3. Trouble falling asleep, 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, weight loss, 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 like school work, reading, or watching TV?	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

For office coding: 0 + ____ + ____ + ____ = Total Score:

10. 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
11. In the past year, have you felt depressed or sad most days, even if you felt OK sometimes?		Yes	No	
12. Has there been a time in the past month when you have had serious thoughts about ending your life?		Yes	No	
13. Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?		Yes	No	