PATIENT HEALTH QUESTIONNAIRE (PHQ) Brief

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

1. 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
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

2. Questions about anxiety.

	YES	NO
In the last 4 weeks, have you had an anxiety attack— suddenly feeling fear or panic? If you checked "NO," go to question 3.	☐	☐
Has this ever happened before?	☐	☐
Do some of these attacks come suddenly out of the blue—that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. If you checked off any problems 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

FOR OFFICE CODING: Maj Dep Syn if answer to #1a or b and five or more of # 1a–i are at least "More than half the days" (count #1i if present at all). Other Dep Syn if #1a or b and two, three, or four of #1a–i are at least "More than half the days" (count #1i if present at all). Pan Syn if all of #2a–e are "YES."

4. In the last 4 weeks, how much have you been bothered by any of the following problems?

	NOT BOTHERED	BOTHERED A LITTLE	BOTHERED A LOT
Worrying about your health	☐	☐	☐
Your weight or how you look	☐	☐	☐
Little or no sexual desire or pleasure during sex	☐	☐	☐
Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
The stress of taking care of children, parents, or other family members	☐	☐	☐
Stress at work outside of the home or at school	☐	☐	☐
Financial problems or worries	☐	☐	☐
Having no one to turn to when you have a problem	☐	☐	☐
Something bad that happened recently	☐	☐	☐
Thinking or dreaming about something terrible that happened to you in the past—like your house being destroyed, a severe accident, or being hit or assaulted	☐	☐	☐

5. In the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? ☐ YES ☐ NO

6. What is the most stressful thing in your life right now? _____

7. Are you taking any medication for anxiety, depression, or stress? ☐ YES ☐ NO

***8.* FOR WOMEN ONLY:** Questions about menstruation, pregnancy, and childbirth.

a. *Which best describes your menstrual periods?*

- ☐ PERIODS ARE UNCHANGED
- ☐ NO PERIODS BECAUSE PREGNANT OR RECENTLY GAVE BIRTH
- ☐ PERIODS HAVE BECOME IRREGULAR OR CHANGED IN FREQUENCY, DURATION, OR AMOUNT
- ☐ NO PERIODS FOR AT LEAST A YEAR
- ☐ HAVING PERIODS BECAUSE TAKING HORMONE REPLACEMENT (ESTROGEN) THERAPY OR ORAL CONTRACEPTIVES

b. *During the week before your period starts, do you have a serious problem with your mood—like depression, anxiety, irritability, anger, or mood swings?* ☐ YES ☐ NO (or does not apply)

c. *If YES, do these problems go away by the end of your period?* ☐ YES ☐ NO

d. *Have you given birth within the last 6 months?* ☐ YES ☐ NO

e. *Have you had a miscarriage within the last 6 months?* ☐ YES ☐ NO

f. *Are you having difficulty getting pregnant?* ☐ YES ☐ NO