Santé
et Services sociaux
Québec

| Patient's last name | File number |
|---|---|
| Patient's first name | |
| Health insurance number | Exp. Year Month |
| Date of birth Year Month Day | Sex ☐ M ☐ F ☐ X ☐ I |
| Address (no., street) | |
| City | Postal Code |

# DEPRESSIVE SYMPTOM ASSESMENT QUESTIONNAIRE PHQ-9

**How often have you been bothered by any of the following problems?**

1. Answer each item based on the last two weeks or the period of time since your last consultation.
2. Use the scale at the top of the table.
3. Answer each item by checking the box that represents your situation the best.

| Items | Not at all 0 | Several days 1 | More than half the days 2 | Nearly every day 3 |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| **2.** Feeling down, depressed, or hopeless. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| **3.** Trouble falling 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 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, such as reading the newspaper or watching television. | ☐ 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 |

*Patient Health Questionnaire* – PHQ-9 © 2002 Kurt Kroenke

| Patient's last name | Patient's first name | File number |
|---|---|---|
| | | |

| Questionnaire completed by: | Date: | | |
|---|---|---|---|
| Signature | Year | Month | Day |
| | | | |

## Section reserved for the practitioner

| | | |
|---|---|---|
| Total score ………………………………………………………………………………. | | |
| Total number of items ……………………………………………………………….. | x | 9 |
| Number of answered items (≥ 7)* ……………………………………………………. | / | |
| Adjusted Score ………………………………………………………………………… | = | |

Is the adjusted score greater than the clinical cut-off value of 10? ………………….   ☐ Yes   ☐ No

Practitioner's qualitative analysis and commentary:

| |
|---|
| |
| |
| |
| |
| |

* If 3 or more answers are missing, the score of the questionnaire cannot be used.

| Questionnaire reviewed by: | | | | Date: | | |
|---|---|---|---|---|---|---|
| Practitioner's last name | Practitioner's first name | Licence number | Signature | Year | Month | Day |
| | | | | | | |