Northeast Kidney Foundation®

PHQ-9 PATIENT HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	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, 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 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	0	1	2	3

Add columns 0 + _____ + _____ + _____

TOTAL: _____

Total Score	Depression Severity
1-4	Minimal Depression
5-9	Mild Depression
Refer to the Mental Health Resource	
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Note: This assessment tool is only used with the purpose to identify possible symptoms of depression and refer patients to seek further medical attention. This is a self-report questionnaire and it is not meant to diagnose a patient. All responses should be verified by a mental health professional and only they can determine a definite diagnosis.