



Board Certified Internal Medicine  
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## Patient Questionnaire - PHQ-9\* Nine Symptom Checklist

Patient 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
	0	1	2	3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless.				
3. Trouble falling/staying asleep, sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
8. Moving or speaking 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.				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
10. If you checked off any problem in 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?				

**Make an appointment with your physician or healthcare professional to discuss your results**

\* Adapted from PRIME-MD