CLIENT FULL NAME:	DATE OF BIRTH: (MON-DD-YYYY)
THERAPIST NAME:	DATE COMPLETED: (MON-DD-YYYY)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Please read this carefully. *Please answer **ALL** questions below by clicking on the button which you think most nearly applies to you. Please hand in the completed questionnaire to your therapist.*

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use **X** or ✓ 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?	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless?	☐	☐	☐	☐
3. Trouble falling or staying asleep, or 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 your family down?	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
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?	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way?	☐	☐	☐	☐

If you checked off any problems, 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
☐	☐	☐	☐

Client Signature: ______________________________________

***Completed By: __________________________________ Role: ____________________________**

**If questionnaire was completed on behalf of the client*

The GAD-7 originates from Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. GAD-7 © Pfizer Inc. all rights reserved; used with permission.