PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

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 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 figety 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		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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	________

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Identity

Please circle your preferred pronouns: she / her(s) he / him / his they / them / their(s)

If *different* than your given name, what is your preferred name? ____________

Can we use your preferred pronouns and preferred name in front of others in the room? YES NO

Body Image

Do you worry about your weight or body composition?	YES	NO
Do you limit or carefully control the foods that you eat?	YES	NO
Do you try to lose weight to meet weight/image/appearance requirements in your sport?	YES	NO
Does your weight affect the way you feel about yourself?	YES	NO
Do you worry that you have lost control over how much you eat?	YES	NO
Do you make yourself vomit or use diuretics or laxatives after you eat?	YES	NO
Do you currently or have you ever suffered from an eating disorder?	YES	NO
Do you ever eat in secret?	YES	NO
Have you ever had a stress fracture?	YES	NO
Are you concerned about acne?	YES	NO
Are you concerned about excessive sweating?	YES	NO

Females Only:

What age was your first menstrual cycle? ____________

Do you have monthly menstrual cycles? YES NO

How many menstrual cycles have you had in the last year (best guess)? ____________

Substance Abuse

In the past YEAR, how many times have you used:

Tobacco?	Never	Once or Twice	Monthly	Weekly or more
Alcohol?	Never	Once or Twice	Monthly	Weekly or more
Marijuana?	Never	Once or Twice	Monthly	Weekly or more

Prescription drugs that were not prescribed to you?

Never Once or Twice Monthly Weekly or more

Illegal Drugs?	Never	Once or Twice	Monthly	Weekly or more
Inhalants?	Never	Once or Twice	Monthly	Weekly or more

Herbs or synthetic drugs (such as salvia, “K2”, or “bath salts”)?

Never Once or Twice Monthly Weekly or more