PHQ-9 Modified for Adolescents (PHQ-A)

(Date of Service: 11/17/2022)

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PEDIATRICS

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Patient:

Today`s Date:

Clinician:

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom, select the answer that best describes how you have been feeling.

1. Feeling down, depressed, irritable, or hopeless?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
2. Little interest or pleasure in doing things?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
4. Poor appetite, weight loss, or overeating?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
5. Feeling tired, or having little energy?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
6. Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
7. Trouble concentrating on things like school work, reading, or watching TV?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
8. Moving or speaking so slowly that other people could have noticed?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day

Or the opposite - being so fidgety or restless that you were moving around a lot more than usual?

9. Thoughts that you would be better off dead, or of hurting yourself in some way? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

TOTAL SCORE:

PLEASE CLICK THE BUTTON BELOW TO SUBMIT YOUR FORM