DARTMOUTH-HITCHCOCK MEDICAL CENTER

PHQ-9 Adolescent Report

For Youth at least 11 years old to complete

Name:_____ Date of Birth:_____ Today's Date:_____

*How often have you been bothered by each of the following symptoms during **the past 2 weeks**. For each symptom, put an "**X**" in the box beneath the answer that bests describes how you have been feeling.*		**(0) Not at All**	**(1) Several Days**	**(2) More than Half the Days**	**(3) Nearly Every Day**
1	Feeling down, depressed, irritable or hopeless?	0	1	2	3
2	Little interest or pleasure in doing things?	0	1	2	3
3	Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4	Poor appetite, weight loss, or over-eating?	0	1	2	3
5	Feeling tired, or having little energy?	0	1	2	3
6	Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
7	Trouble concentrating on things like school work, reading, or watching TV?	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 were moving around a lot more than usual?	0	1	2	3
9	Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3
10	In the **past year**, have you felt depressed or sad most days, even if you felt okay sometimes? [ ] Yes [ ] No				
11	If you are experiencing any of the problems on this form, **how difficult** have these problems made it for you to do work, take care of things at home, or get along with other people? [ ] Not difficult at all [ ] Somewhat difficult [ ] Very Difficult [ ] Extremely Difficult				
12	Has there been a time in the **past month** when you have had serious thoughts about ending your life? [ ] Yes [ ] No				
13	Have you **EVER,** in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? [ ] Yes [ ] No				