



Initial Assessment     \_\_\_\_\_ - Day Reassessment     Discharge

**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 fidgety 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 in some way	0	1	2	3

For Office Coding

Total Score:   0   +        +        +        =       

**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

**Patient** (signature): \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

If patient is unable to complete:

**Completed by** (signature): \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Completed by** (print name): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Clinician** (signature): \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Clinician** (print name): \_\_\_\_\_

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

**Interpreter Information** (To be completed by Inova staff, if applicable):

In person     Telephonic     Video    Interpreter name/ID number (if applicable) \_\_\_\_\_  
 Patient/Designated Decision Maker was offered and refused interpreter     Waiver Signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medical Record # \_\_\_\_\_

Gender:  Male  Female

**Inova Patient Health Questionnaire-9 (PHQ-9)**

IAH     IFH     IFOH     ILH     IMVH

