

<b>PATIENT HEALTH QUESTIONNAIRE - 9</b>					72883
<b>THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.</b>					
Were data collected? No <input type="checkbox"/> (provide reason in comments) If Yes, data collected on visit date <input type="checkbox"/> or specify date: _____ <div style="text-align: right; font-size: small;">DD-Mon-YYYY</div>					
<i>Comments:</i>					
<b>Only the patient (subject) should enter information onto this questionnaire.</b>					
<b>Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?</b>	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>	<b>Nearly every day</b>	
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	
					<b>SCORING FOR USE BY STUDY PERSONNEL ONLY</b> _____ + _____ + _____ + _____ =Total Score: _____
<b>If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?</b>					
<b>Not difficult at all</b> <input type="checkbox"/>	<b>Somewhat difficult</b> <input type="checkbox"/>	<b>Very difficult</b> <input type="checkbox"/>	<b>Extremely difficult</b> <input type="checkbox"/>		
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<b>I confirm this information is accurate.</b>	Patient's/Subject's initials:			Date:	