FLORIDA linc Linking Individuals Needing Care

Florida Linking Individuals Needing Care Project

PHQ-9 Screening Tool

Your Name:		Date:	
Home Phone #:		Guardian's Name:	
E-mail Address:		Cell Phone #:	
Referral Source:		Relation to Above:	

Please read each question below very carefully and determine which amount of time most closely describes your current situation.

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all (<1 day)	Several days	More than half the days	Nearly every day
A. Feeling down, depressed, irritable, or hopeless?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
B. Experienced little interest or pleasure in doing things?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
C. Had trouble falling asleep, staying awake or sleeping too much?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
D. Experienced poor appetite, weight loss or overeating?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
E. Feeling tired or having little energy?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
F. 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)
G. Had trouble concentrating on things like school work, reading or watching tv?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
H. Felt that you were moving or speaking so slowly that others could have noticed? Or so fidgety or restless that you were moving around a lot more than usual?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
I. Thoughts that you would be better off dead or of hurting yourself in some way?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
Column Subtotal				

TOTAL

J. How difficult have the items above made it for you to do your school work, take care of things at home, or get along with other people?

☐ Not Difficult at All ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult