Patient Name:______________________ Today's Date: ___________________

DOB: ________________________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, 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 __*0*__ + ______ + ______ + ______

=Total Score: ______

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?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

For Doctor only: ***If PHQ-9 score >= 10 Treatment plan*****:**

Physician Signature: ______________________________________**Date:**

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.

Patient Name:____________________   Today's Date: ____________________
DOB: _____________________

For Office Only:

Height:________   Weight: _____________   *BMI:____________

If BMI <23 or >=30 for a patient aged >=65 or BMI <18.5 or >= 25 for patients aged 18-64 a plan is indicated.

Patients Please answer questions 2 through 7

2. **Falls Screening:**

   Have you had two or more falls in the past twelve months? Please circle YES or NO

   Have you fallen in the past twelve months with injury? Please circle YES or NO

3. **Tobacco Screening:**

   Do you currently smoke or chew Tobacco? Please circle YES or NO

4. **Flu shot:**

   Have you received a flu shot during the months of October 2014- March 2015?

   Please circle YES or NO

5. **Pneumonia shot:**

   Have you EVER received a pneumonia shot? Please circle YES or NO
   If Yes, approximately what year did you receive this vaccine? ___________________

6. **Colon Cancer Screening:**

   Have you ever received a colonoscopy? Please circle YES or NO
   If Yes, approximately what year did you receive this test? _____________
   What were the results: Please circle Positive or Negative

7. **Breast Cancer Screening:**
   If you are a female, Have you received a mammogram in either year 2014 or 2015?
   Please circle YES or NO
   What were the results: Please circle Positive or Negative

For Doctors: Patient Education/Counseling   Please Circle as applicable

-Smoking Cessation   -Physical Activity/Exercise
-Diet/Nutrition/Ideal Weight   -Healthy Lifestyle
-Test/Procedures   -Cancer Screening Prevention
-Medication Use of Side Effects Rx: ___________________________________
-Chronic Disease Education Dx: ______________________________________

Physician Signature: ______________________________________ Date: ____