Name ______________________________ DOB _______________________ Date______________

PATIENT HEALTH QUESTIONNAIRE
PHQ-9

Over the <u>last 2 weeks,</u> how often have you been bothered by any of the following problems?	**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 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
add columns	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 (circle best answer)	**Not difficult at all**	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

INTIMATE PARTNER VIOLENCE ASSESSMENT

1. Has your current partner or former partner threatened you or made you feel afraid? (stalked you, insulted you, threatened you with a weapon, threatened to hurt you or your children if you did or didn't do something, controlled whom you talk to/where you go/how you spend money)	**Yes**	**No**
2. Has your partner hit, strangled or physically hurt you? (hurt includes being hit, slapped, kicked, choked [or strangled], bitten, shoved)	**Yes**	**No**
3. Has your partner made you have sex when you didn't want to?	**Yes**	**No**