Charles Drew
HEALTH CENTER, INC.
*"Growing a Healthy Community"*

# PATIENT HEALTH QUESTIONNAIRE

Please check the number that best describes your answer to each question.

First Name: ______________________ Last Name: ____________________________ Date: ________________

Social Security Number (SSN): ________________________ Date of Birth (mm/dd/yyyy): ________________________

| Over the last 2 weeks, how often have you been bothered by any of the following problems? | (0) Not at all | (1) Several days | (2) More than half the days | (3) Nearly daily |
|---|---|---|---|---|
| 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 |
| 10. If you are experiencing any of the problems on this form, 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 |
| 11. In the past two years, have you felt depressed or sad most days, even if you felt okay sometimes? | ☐ Yes | ☐ No | | |
| 12. Have you been having thoughts of hurting yourself in some way? | ☐ Yes | ☐ No | | |

## FOR OFFICE USE ONLY

Add scores for each column for questions 1–9.

☐ + ☐ + ☐

*0-9 = Minor to Minimal*
*5-9 = Minor*
*10-14 = Moderate*
*15-19 = Moderate to Severe*

Total Severity: /27

Total Symptoms: /5