

Brief Patient Health Questionnaire™ (PHQ-Brief)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

Name _____ Age _____ Sex: Female Male Today's Date _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Sever al days	More than half the days	Nearl y every day
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Questions about anxiety.

a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	NO <input type="checkbox"/>	YES <input type="checkbox"/>
--	---------------------------------------	--

If you checked "NO", go to question #3.

b. Has this ever happened before?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	<input type="checkbox"/>	<input type="checkbox"/>
d. Do these attacks bother you a lot or are you worried about having another attack?	<input type="checkbox"/>	<input type="checkbox"/>
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	<input type="checkbox"/>	<input type="checkbox"/>

3. If you checked off any problems on this questionnaire so far, 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

- | 4. In the last 4 weeks, how much have you been bothered by any of the following problems? | Not
bothered | Bothered
a little | Bothered
a lot |
|---|--------------------------|--------------------------|--------------------------|
| a. Worrying about your health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Your weight or how you look | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Little or no sexual desire or pleasure during sex | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The stress of taking care of children, parents, or other family members | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Stress at work outside of the home or at school | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Financial problems or worries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Having no one to turn to when you have a problem | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Something bad that happened <u>recently</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Thinking or dreaming about something terrible that happened to you <u>in the past</u> - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|---|--------------------------------|---------------------------------|
| 5. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? | NO
<input type="checkbox"/> | YES
<input type="checkbox"/> |
|---|--------------------------------|---------------------------------|

6. What is the most stressful thing in your life right now? _____

- | | | |
|---|--------------------------------|---------------------------------|
| 7. Are you taking any medicine for anxiety, depression or stress? | NO
<input type="checkbox"/> | YES
<input type="checkbox"/> |
|---|--------------------------------|---------------------------------|

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth.

- a. Which best describes your menstrual periods?

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Periods are unchanged | <input type="checkbox"/> No periods because pregnant or recently gave birth | <input type="checkbox"/> Periods have become irregular or changed in frequency, duration or amount | <input type="checkbox"/> No periods for at least a year | <input type="checkbox"/> Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive |
|--|---|--|---|---|

- | | NO
(or does not apply) | YES |
|--|---------------------------|--------------------------|
| a. During the week before your period starts, do you have a <u>serious</u> problem with your mood - like depression, anxiety, irritability, anger or mood swings | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If YES: Do these problems go away by the end of your period? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have you given birth within the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you had a miscarriage within the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Are you having difficulty getting pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |