wasatch pediatrics

A Survey from your Health Care Provider
PHQ-9 Modified for Teens

Child's Name: _____ Today's Date: _____

Date of Birth: _____Clinician_____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks?
For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

Symptoms	(0) Not at all	(1) Several Days	(2) More than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable or hopeless? May include: feeling sad, tearful, hopeless, isolates self from others, feels down, intense anger ,temper tantrums, aggression, inability to deal with frustration				
2. Little interest or pleasure in doing things? May include: loss of interest in activities they once found pleasurable, has stopped participating in previous activities (sports, dance, etc.), nothing is fun				
3. Trouble falling asleep, staying asleep or sleeping too much? May include: trouble getting to sleep, wakes frequently, naps during the day, gets to sleep late and wakes early, sleeps all the time				
4. Poor appetite, weight loss, or overeating? May include: loss of appetite, significant weight loss(____lbs.) increased appetite, significant weight gain (____lbs.)				
5. Feeling tired or having little energy? May include: tired all the time, doesn't feel up to doing anything, less active than usual, slow speech, seems slowed down				
6. Feeling bad about yourself- or feeling that you are a failure, or that you have let yourself or your family down? May include: inappropriate guilt, excessive guilt, poor self-esteem, makes negative statements about self				
7. Trouble concentrating on things like school work, reading or watching TV? May include: can't focus, short attention span, poor listening, easily distracted, can't think, indecisive				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you are moving around a lot more than usual?				
9. Thought that you would be better off dead, or of hurting yourself in some way? May include: suicidal gestures, self harm, thoughts of suicide, suicide plan, suicide attempt				

10. In the **past year** have you felt depressed or sad **most** days, even if you felt okay sometimes? ☐ Yes ☐ No

11. 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 school or get along with other people?

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

12. Has there been a time in the last month when you have had serious thought about ending your life? ☐ Yes ☐ No

13. Have you **ever**, in your **whole life**, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

**If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911

FOR OFFICE USE ONLY **Score** _____
Q. 12 and 13=Y or TS= ≥ 11