**PHQ-9 Depression Screening Tool**

This is a screening measure to help you determine whether you might have depression that needs professional attention. This screening tool is not designed to make a diagnosis of depression but to be shared with your primary care physician or mental health professional to inform further conversations about diagnosis and treatment.

**Over the last two weeks, how often have you been bothered by any of the following problems?**

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| --- | --- | --- | --- | --- |
|  | Not at all(0) | Several days (1) | More than half of the days(2) | Nearly every day(3) |
| 1. Little interest or pleasure in doing things |  |  |  |  |
| 2. Feeling down, depressed, or hopeless |  |  |  |  |
| 3. Trouble falling or staying asleep, or sleeping too much |  |  |  |  |
| 4. Feeling tired or having little energy |  |  |  |  |
| 5. Poor appetite or overeating |  |  |  |  |
| 6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down |  |  |  |  |
| 7. Trouble concentrating on things such as reading the newspaper or watching television |  |  |  |  |
| 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 |  |  |  |  |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way |  |  |  |  |

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| **If you checked off any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with others?**  Not difficult at all  Somewhat difficult  Very difficult  Extremely difficult  **If you scored 4 or higher please contact Cognitive Behavior Therapy and Wellness Center at 516-382-4567 for more information and to speak with someone who can help you.** |