Patient Health Questionnaire-9 (PHQ-9) 2019

Client Last Name	Client First Name	Client DOB
Child Last Name	Child First Name	Child DOB
Today's Date ____/____/_______	Home Visitor/Provider Name	

Check one: ☐ Intake ☐ Pregnancy 36 weeks ☐ 1 to 8 Weeks Postpartum ☐ Infancy 4-6 months
☐ Infancy 12 months ☐ Other: ________________________ (specify time frame)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and check your response.

1. Little interest or pleasure in doing things
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day

2. Feeling down, depressed, or helpless
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day

3. Trouble falling asleep, staying asleep, or sleeping too much
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day

4. Feeling tired or having little energy
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day

5. Poor appetite or overeating
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day

6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day

7. Trouble concentrating on things such as reading the newspaper or watching television
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day

8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day

9. Thinking that you would be better off dead or that you want to hurt yourself in some way
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day

Total Score=_____________

10. If you checked off any problems on this questionnaire, 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

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Patient Health Questionnaire-9 (PHQ-9)
Form No. 1213

Purpose: The PHQ-9 is a multipurpose instrument for screening a broad range of clients for depression. OSDH **Family Planning** will use this tool to identify clients in clinic and OSDH **Home Visitation** programs will use this to tool to assist in identifying men and women enrolled in home based services who are experiencing signs of depression.

Use: This form is administered during all of the time points indicated on the form and when signs or symptoms indicate the need for screening.

Client – Provide the last name, first name and date of birth of client.

Child – (**Home Visiting only**) Provide the last name, first name and date of birth of child.

Date – Provide the date the questionnaire was administered.

Home Visitor/Provider Name – Provide the name of the home visitor or provider administering the questionnaire.

Time Frame – (**Home Visiting only**) Check the box indicating the appropriate screening time frame.

The PHQ-9 consists of 10 short statements, each with four responses. The client checks the response that most closely matches how he/she has been feeling in the previous 14 days. Response categories are scored 0, 1, 2, and 3, according to the severity of the symptom.

- Not at all = 0
- Several days = 1
- More than half the days = 2
- Nearly every day = 3

All 10 items must be completed. The total score is calculated by adding together the scores for the first 9 items and should be documented on the client's visit note of the same day. If the client answers "Somewhat Difficult", "Very Difficult" or "Extremely Difficult" on question #10, this suggests that the client's functional status is impaired. The total score can be interpreted as below.

Total Score	Depression Severity
1-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Clients with scores of 10 or above OR clients who answer question #9 '"Several Days," "More than half the days," or "Nearly Every Day" <u>warrant a referral to the Primary Care Provider and/or a local mental health professional. If a referral is indicated, a release of information should be signed to enhance the opportunity for follow-up regarding linkage of services.</u> Follow-up should be done no later than two weeks after the referral has been made in an effort to assure the client has linked with needed services. For those women who score between 5-9, provide client with educational materials on the symptoms, protective factors, and resources for perinatal mental health concerns along with a local resource list when possible.

While completing the questionnaire, care should be taken to avoid the possibility of the client discussing her answers with others. The client should complete the PHQ-9 him/herself, unless he/she has limited English or has difficulty reading.

Routing and Filing: The original copy of this form is filed in the client's OSDH record.