TO BE COMPLETED BY THE PATIENT

Responses and discussion are confidential

CONFIDENTIAL PHQ – 9 ADOLESCENT SCREENING FORM

NAME: _____ DATE: _____

D.O.B. _____ MRN # _____

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

		Not at all	Several days	More than half the days	Nearly every day
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. Have you ever had sex? No Yes

11. Have you ever been a victim of physical or sexual abuse? No Yes

12. Do you ever smoke cigarettes, vape or use Juul? No Yes

13. Do you ever smoke marijuana or hashish? No Yes

14. Do you use any other illegal drugs, prescriptions drugs or over the counter medications to get high? No Yes

15. Do you drink alcohol (more than a few sips?) No Yes
(do not count sips of alcohol taken for family or religious events)

16. What do you like most about yourself? _____