Physicians to Children. Inc.

CONFIDENTIAL PHQ-9 ADOLESCENT SCREENING FORM

Name: _____ Date: _____

DOB: _____ MR#: _____

TO BE COMPLETED BY THE PATIENT

Responses and discussion are confidential

Over the last 2 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	○	○	○	○
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	○	○	○	○

10. Have you ever had sex? **No** **Yes**

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

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

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

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

15. Do you drink any alcohol (more than a few sips) **No** **Yes**

(Do not count sips of alcohol taken during family or religious events)

16. What do you like most about yourself?