# *Patient Health Questionnaire 9 Modified for Adolescents (PHQ-9-M)*

*(complete fields or place patient label here)*

| Patient Name *(First, Middle, Last)* | |
|---|---|
| Birth Date *(mm-dd-yyyy)* | Room Number (if applicable) |
| Mayo Clinic Number | |

Form content retained in medical record.
**Discard after electronic entry.**

**BACKUP**

Outage Date _____ *(mm-dd-yyyy)* Outage Time _____ *(hh:mm 24-hour clock)*

**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.

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling down, depressed, irritable, or hopeless? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 2. Little interest or pleasure in doing things? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 3. Trouble falling asleep, staying asleep, or sleeping too much? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 4. Poor appetite, weight loss, or overeating? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 5. Feeling tired, or having little energy? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 7. Trouble concentrating on things like school work, reading, or watching TV? | ☐ 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 were 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 |
| add columns | | _____ + _____ + _____ | | |
| **Total** | | | | |

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

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 get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life? ☐ Yes ☐ No

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 Provider, go to a hospital emergency room or call 911.