

McLaren Print System Order

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 User: Shantell Moore
 Phone: 231-679-3915

Ship Location: Standish Family Medicine
 4489 M-61, Suite 1
 Standish , MI 48658

Forms

Quantity: 500
 Paragon Dept No: 56028
 Dept Name: Standish Family Medicine
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-3381
 Item Description: Patient Health Questionnaire (PHQ-‐9)
 Revision Date: 9/2018
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Misc Info: ds; black; bond



Patient Health Questionnaire (PHQ-9)

Patient Name (First, Last) _____ Date of Birth _____

Review the questions. Circle each answer and calculate the score.

Over the past 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	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, 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 would 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

Add the Score for Each Column
 Add Column Totals Together _____ = _____ + _____ = _____

10. If you circled any problems, how difficult have those 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

The PHQ questionnaire was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer, Inc.

Reviewed by: _____
 Provider's Signature (Required) _____ Date & Time (Required) _____