McLaren Business Products

McLaren Print System Order

Order No: 69073
Order Date: 2022-04-14
User: Bobbi O'Grady
Phone: 231-627-1333

Ship Location: Cheboygan Med Center
740 S. Main St., Suite 3B
Cheboygan, MI 49721
Brochures
Quantity: 100
Paragon Dept No: 50678
Dept Name: Mclaren Medical Group
Company Number: 810

Order Total Price: 0.00

Item Number: MO-411
Item Description: PHQ - Questions
Revision Date: 1/2020
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill:
Misc Info: ss; black; 20#

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: ______________________ Date of Birth: ____________ Today's Date: ____________

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)	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	0	1	2	3
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:				

10. If you checked off any problems, 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	______

Patient Signature: ______________________ Date: ______________ Time: ______________

Physician Signature: ______________________ Date: ______________ Time: ______________

Spec Info: