

McLaren Print System Order

Order No: 73720 Reprint Previous Order No: 40560
 Order Date: 2022-11-18
 User: Graphics Dept
 Phone: 810-342-4407

Ship Location: McLaren Flint
 401 S Ballenger Hwy
 Flint, MI 48532

Forms

Quantity: 100
 Paragon Dept No: 10000
 Dept Name: McLaren Health Care
 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 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

Add the Score for Each Column
 Add Column Totals Together _____

10. If you checked 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

The PHQ-9 questionnaire was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, and 4 weeks and colleagues, with an endorsement from DSM-5.

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