Adapted Patient Health Questionnaire (aPHQ-9)

Name: _____ ***Date:*** _____

In the last two weeks, how often have you been feeling the following? (Use a "✓" to indicate your answer)	None	A little bit	Most of the time	All of the time
1. Have you been feeling slack, not wanted to do anything?	☐ 0	☐ 1	☐ 2	☐ 3
2. Have you been feeling unhappy, depressed, really no good, that your spirit was sad?	☐ 0	☐ 1	☐ 2	☐ 3
3. Have you found it hard to sleep at night, or had other problems with sleeping?	☐ 0	☐ 1	☐ 2	☐ 3
4. Have you felt tired or weak, that you have no energy?	☐ 0	☐ 1	☐ 2	☐ 3
5a. Have you not felt like eating much even when there was food around?	☐ 0	☐ 1	☐ 2	☐ 3
5b. Have you been eating too much food?	☐ 0	☐ 1	☐ 2	☐ 3
6. Have you been feeling bad about yourself, that you are useless, no good, that you have let your family down?	☐ 0	☐ 1	☐ 2	☐ 3
7. Have you felt like you can't think straight or clearly, it's hard to learn new things or concentrate?	☐ 0	☐ 1	☐ 2	☐ 3
8a. Have you been talking slowly or moving around really slow?	☐ 0	☐ 1	☐ 2	☐ 3
8b. Have you felt that you can't sit still; you keep moving around too much?	☐ 0	☐ 1	☐ 2	☐ 3
9. Have you been thinking about hurting yourself or killing yourself?	☐ 0	☐ 1	☐ 2	☐ 3

Add columns: _____ + _____ + _____

Total: _____

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