

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been feeling unhappy, depressed, really no good, that your spirit was sad?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you found it hard to sleep at night, or had other problems with sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you felt tired or weak, that you have no energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5a*. Have you not felt like eating much even when there was food around?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5b*. Have you been eating too much food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been feeling bad about yourself, that you are useless, no good, that you have let your family down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you felt like you can't think straight or clearly, it's hard to learn new things or concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8a*. Have you been talking slowly or moving around really slow?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8b*. Have you felt that you can't sit still; you keep moving around too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you been thinking about hurting yourself or killing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Add columns: + +
Total: _____

Total score range 0-27

*Note: Scores for depressive symptoms - record only the highest value (from 5a and 5b; from 8a and 8b) in both of these sub-questions.

To screen for depression:

1. For questions 5a and 5b, score only one response – the higher scoring answer for either 5a or 5b
2. For questions 8a and 8b, score only one response – the higher scoring answer for either 8a or 8b
3. Add up ✓s by column. For every ✓: A little bit = 1, Most of the time = 2, All of the time = 3
4. Add together column scores to get a TOTAL score.
5. People scoring 10 or more points (TOTAL score) require further assessment of their social and emotional wellbeing.