How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom, put an “X” in the box beneath the answer that best describes how have you been feeling.

1. Feeling down, depressed, or hopeless?

\_ 0. Not at all \_ 1. Several days \_ 2. More than half the days \_ 3. Nearly every day

1. Little interest or pleasure in doing things?

\_ 0. Not at all \_ 1. Several days \_ 2. More than half the days \_ 3. Nearly every day

1. Trouble falling asleep, staying asleep, or sleeping too much?

\_ 0. Not at all \_ 1. Several days \_ 2. More than half the days \_ 3. Nearly every day

1. Poor appetite, weight loss, or overeating?

\_ 0. Not at all \_ 1. Several days \_ 2. More than half the days \_ 3. Nearly every day

1. Feeling tired, or having little energy?

\_ 0. Not at all \_ 1. Several days \_ 2. More than half the days \_ 3. Nearly every day

1. Feeling bad about yourself — or that you are a failure or that you have let yourself or your family down?

\_ 0. Not at all \_ 1. Several days \_ 2. More than half the days \_ 3. Nearly every day

1. Trouble concentrating on things, like school work, reading, or watching TV?

\_ 0. Not at all \_ 1. Several days \_ 2. More than half the days \_ 3. Nearly every day

1. 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. Not at all \_ 1. Several days \_ 2. More than half the days \_ 3. Nearly every day

1. Thoughts that you would be better off dead or of hurting yourself in some way

\_ 0. Not at all \_ 1. Several days \_ 2. More than half the days \_ 3. Nearly every day

*[continued next page]*

1. In the past year, have you felt depressed or sad most days, even if you felt okay sometimes?

\_ 1. Yes \_ 0. No

1. If you are experiencing any of the problems on this form, 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?

\_ 0. Not difficult at all \_ 1. Somewhat difficult \_ 2. Very difficult \_ 3. Extremely Difficult

1. Has there been a time in the past month when you have had serious thoughts about ending your life?

\_ 1. Yes \_ 0. No

1. Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?

\_ 1. Yes \_ 0. No

*Refrain from providing the following information to participants:*

Notes

PHQ-M (modified for teens) and PHQ-A (modified for adolescents) are identical. There is an adapted version of the PHQ-A that only uses the first 9 questions.

Administering:

* The Patient Health Questionnaire Modified for Teens (PHQ-Modified) can be used with patients between the ages of 12 and 18 and takes less than five minutes to complete and score.
* The PHQ-9 Modified can be administered and scored by a nurse, medical technician, physical assistant, physician or other office staff.
* Patients should be left alone to complete the PHQ-9 Modified in a private area, such as an exam room or private area of the waiting room.
* Patients should be informed of their confidentiality rights before the PHQ-9 Modified is administered.
* The American Academy of Pediatrics and U.S. Preventive Service Task Force recommend that depression screening be conducted annually.

Scoring:

* For every X:

Not all = 0

Several days= I

More than half the days=2

Nearly every day=3

Sum the scores for questions 0 through 9

* Defining a Positive Screen on the PHQ-9 Modified:

Total scores >=11 are positive

* Suicidality:

Regardless of the PHQ-9 Modified total score, endorsement of serious suicidal ideation OR past suicide attempt (question 12 and 13 on the screen) should be considered a positive screen.

Interpreting the Screening Results

* Patients that score positively on the questionnaire should be evaluated by their primary care provider (PCP) to determine if the depression symptoms they endorsed on the screen are significant, causing impairment and/or warrant a referral to a mental health specialist or follow-up treatment by the PCP.
* It is recommended that the PCP inquire about suicidal thoughts and previous suicide attempts with all patients that score positive, regardless of how they answered these items on the PHQ-9 Modified.
* For patients who score negative on the PHQ-9 Modified, it is recommended that the PCP briefly review the symptoms marked as "more than half days" and "nearly every day" with the patient.
* The questionnaire indicates only the likelihood that a youth is at risk for depression or suicide; its results are not a diagnosis or a substitute for a clinical evaluation.

Depression Severity

* The overall score on the PHQ-9 Modified provides information about the severity of depression, from minimal depression to severe depression.
* The interview with the patient should focus on their answers to the screen and the specific symptoms with which they are having difficulties.
* Additional questions on the PHQ-9 Modified also explore persistent depressive disorder, impairment of depressive symptoms, recent suicide ideation and previous suicide attempts.

Interpretation of Total Score

Total Score Depression Severity

1-4 Minimal depression

5-9 Mild depression

10-14 Moderate depression

15-19 Moderately severe depression

20-27 Severe depression

References:

Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep;16(9):606-13.

Johnson JG, Harris ES, Spitzer RL, Williams JB. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002 Mar;30(3):196-204