

The Adolescent Patient Health Questionnaire (PHQ-A)

Patient Name _____ Date of Visit _____

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. Feeling down, depressed, or hopeless	0	1	2	3
2. Little interest or pleasure in doing things	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Poor appetite, weight loss, or overeating	0	1	2	3
5. Feeling tired or having little energy	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as school work, reading or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or 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

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

Yes No

11. If you are experiencing any of the problems above, 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

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

Yes No

13. Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

Yes No

Do you have comments to make? Maximum of 100 characters: