

KIDS HEALTH ALLIANCE PA
PHQ-9 MODIFIED FOR TEENS

NAME: _____ DATE: _____

PLEASE BUBBLE IN COMPLETELY

How often have you/your child been bothered by each of the following symptoms during the past two weeks?

- 1. Feeling down, depressed, irritable, or hopeless?**
 Not at all (0) Several days (1) More than half the days (2) Nearly every day (3)
- 2. Little interest or pleasure in doing things?**
 Not at all Several days More than half the days Nearly every day
- 3. Trouble falling asleep, staying asleep, or sleeping too much?**
 Not at all Several days More than half the days Nearly every day
- 4. Poor appetite, weight loss, or overeating?**
 Not at all Several days More than half the days Nearly every day
- 5. Feeling tired, or having little energy?**
 Not at all Several days More than half the days Nearly every day
- 6. Feeling bad about yourself or feeling that you are a failure?**
 Not at all Several days More than half the days Nearly every day
- 7. Trouble concentrating on things?**
 Not at all Several days More than half the days Nearly every day
- 8. Moving or speaking so slowly that other people notice?**
 Not at all Several days More than half the days Nearly every day
- 9. Thoughts that you would be better off dead or hurt yourself?**
 Not at all Several days More than half the days Nearly every day

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

Yes No

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?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

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

Yes No

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

Yes No

Medication Side Effects

Sedation	<input type="radio"/> No	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	
Restlessness	<input type="radio"/> No	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	
Irritability	<input type="radio"/> No	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	
Headaches	<input type="radio"/> No	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	
Stomach Aches	<input type="radio"/> No	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	
Mania	<input type="radio"/> No	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	
Sexual Side Effects	<input type="radio"/> N/A	<input type="radio"/> No	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe

1-4 minimal; 5-9 mild; 10-14 moderate; 15-19 moderate-severe; 20-27 severe.

Some improvement at 4-8 wks : adjust or increase dose if therapy was used alone add antidepressants,
No improvement at 4-8 week : change med to a different class, reassess No or partial improvement in 8 weeks: refer to a psychiatrist