

Adult Outcomes Questionnaire 1.4

Name _____ Medical Record # _____ Date _____

PHQ-9 Over the last two weeks, how often have you been bothered by any of the following problems? (Circle only one number per line)		Not at all	Several Days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down depressed or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	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	1	2	3
9.	Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

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Add the circled numbers in each column, then add the sums: 0 + = A

10.	Feeling nervous, anxious or on edge	0	1	2	3
11.	Not being able to stop or control worrying	0	1	2	3
12.	Feeling unproductive at work or other daily activities	0	1	2	3
13.	Having trouble focusing on achieving your goals	0	1	2	3

Add the circled numbers in each column, then add the sums: 0 + = B

TOTAL (A + B) =

If you have had a visit in the Mental Health Department, circle the number that BEST matches your feelings about your most recent visit		Only a little or not at all	Sometimes	Quite a bit	Totally
1.	In the session, we discuss the things that are most important to me.	0	1	2	3
2.	I feel understood and respected by my clinician.	0	1	2	3
3.	I understand and agree with my treatment plan.	0	1	2	3

Goodness of Fit score: 0 + = F