**PATIENT MENTAL HEALTH QUESTIONNAIRE**

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| --- | --- | --- | --- | --- |
| Over the **last 2 weeks**, how often have you been bothered by any of the following problems? Circle your answer. | Not at all | Several days | More than half the days | Nearly every day |
| Little interest or pleasure in doing things. | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless. | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much. | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy. | 0 | 1 | 2 | 3 |
| Poor appetite or overeating. | 0 | 1 | 2 | 3 |
| Feeling bad about yourself-or that you are a failure or have let yourself or your family down. | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television. | 0 | 1 | 2 | 3 |
| 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 |
| Thoughts that you would be better off dead or of hurting yourself in some way. | 0 | 1 | 2 | 3 |
| Column Totals: | 0 |  |  |  |
| Total Score | | | |  |

If you checked off **any** problems, how **difficult** have these problems made it for you to do your school work, take care of things at home, or get along with other people?

❒ Not difficult at all

❒ Somewhat difficult

❒ Very difficult

❒ Extremely difficult

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