# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:** ______________________________ **DATE:** ______________

| Over the last 2 *weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)* | **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 figety 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 | 0 | 1 | 2 | 3 |
| | add columns | + | + | |

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).* TOTAL:

| **10.** If you checked off *any problems*, 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 ______ |

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A2663B 10-04-2005

## FALL RISK CHECKLIST

**PATIENT:______________________________________DATE:_________________**

**FALL RISK IDENTIFIED? Yes____No____ If yes describe the risk:______________**

______________________________________________________________________

______________________________________________________________________

**FALLS HISTORY:**

**Any falls in the past year? Yes____No____**

**Worried about falling or feel unsteady when standing or walking? Yes___No___**

**MEDICAL CONDITIONS:**

**Problems with heart rate and/or rhythm** **Yes____No____**

**Foot Problems** **Yes____No____**

**Cognitive Impairment** **Yes____No____**

**Incontinence** **Yes____No____**

**Depression** **Yes____No____**

**Other medical conditions (specify)** **Yes____No____**

**If yes describe:_______________________________________________________**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________