A Survey From Your Healthcare Provider — PHQ-9 Modified for Teens

Name_____ Clinician_____

Medical Record or ID Number_____ Date_____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

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 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

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

FOR OFFICE USE ONLY **Score**_____

Q. 12 and Q. 13 = Y or TS = ≥11

Source: Patient Health Questionnaire Modified for Teens (PHQ-9) (Author: Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

PC/PHQ-9 Mod/6.7.11/2000

A Survey From Your Healthcare Provider — PSC-Y

Name	Date	ID

	Please mark under the heading that best fits you or circle Yes or No	Never 0	Sometimes 1	Often 2
-	1. Complain of aches or pains			
-	2. Spend more time alone			
-	3. Tire easily, little energy			
●	4. Fidgety, unable to sit still			
-	5. Have trouble with teacher			
-	6. Less interested in school			
●	7. Act as if driven by motor			
●	8. Daydream too much			
●	9. Distract easily			
-	10. Are afraid of new situations			
▲	11. Feel sad, unhappy			
-	12. Are irritable, angry			
▲	13. Feel hopeless			
●	14. Have trouble concentrating			
-	15. Less interested in friends			
■	16. Fight with other children			
-	17. Absent from school			
-	18. School grades dropping			
▲	19. Down on yourself			
-	20. Visit doctor with doctor finding nothing wrong			
-	21. Have trouble sleeping			
▲	22. Worry a lot			
-	23. Want to be with parent more than before			
-	24. Feel that you are bad			
-	25. Take unnecessary risks			
-	26. Get hurt frequently			
▲	27. Seem to be having less fun			
-	28. Act younger than children your age			
■	29. Do not listen to rules			
-	30. Do not show feelings			
■	31. Do not understand other people's feelings			
■	32. Tease others			
■	33. Blame others for your troubles			
■	34. Take things that do not belong to you			
■	35. Refuse to share			
◆	36. During the past three months, have you thought of killing yourself?		Yes	No
◆	37. Have you ever tried to kill yourself?		Yes	No

FOR OFFICE USE ONLY

Plan for Follow-up ☐ Annual screening ☐ Return visit w/ PCP ☐ Referred to counselor
☐ Parent declined ☐ Already in treatment ☐ Referred to other professional

TS _____

Q 36 or Q 37=Y ◆ TS ≥ 30

Source: Pediatric Symptom Checklist – Youth Report (PSC-Y)