PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:	<u> </u>				
Over the last 2 weeks, how often have you been bothered by any of the following problems?					
(use ">" to indicate your enswer)	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 TOTA please refer to accompanying scoring card).	L, TOTAL:			,	
10. If you checked off any problems, how difficult	Not difficult at all				
have these problems made it for you to do	Somewhat difficult				
your work, take care of things at home, or get	Very difficult				
along with other people?					
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Patient Name:	 	
Date		

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	in the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2.	Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3.	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4.	Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5.	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6.	Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7.	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8.	Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9.	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10.	Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11.	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12.	Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13.	Feeling distant or cut off from other people?	0	1	2	3	4
14.	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15.	Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
	Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17.	Being "superalert" or watchful or on guard?	0	1	2	3	4
	Feeling jumpy or easily startled?	0	1	2	3	4
19.	Having difficulty concentrating?	0	1	2	3	4
20.	Trouble falling or staying asleep?	0	1	2	3	4