

Healing Hand Healthcare LLC

PHQ-9 Questionnaire

Answer all questions listed below to the best of your ability. If this form is not filled out in its entirety it will be requested to be filled out prior to conducting interview, receiving treatment, or having prescriptions refilled.

Name _____ M.I. _____

Date of Birth: _____ SSN: _____

Options:

Not at all Several days More than half the days Nearly every day

Over the last two weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things? _____
2. Feeling down, depressed, or hopeless? _____
3. Trouble falling or staying asleep, or sleeping too much? _____
4. Feeling tired or having little energy? _____
5. Poor appetite or overeating? _____
6. Feeling bad about yourself or that you are a failure, or you have let yourself or your family down? _____
7. Trouble concentrating on things, such as reading the newspaper or watching television? _____
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? _____
9. Thoughts that you would be better off dead or of hurting yourself? _____

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? _____

Options: Not difficult at all Somewhat difficult Very difficult Extremely difficult

Disclosure and Acknowledgement:

By signing you confirm all selections are true or have been provided by a representative of the patient or by the patient. Only the patient or the legal representative may sign or provide data in this form. The legal representative must first be acknowledged by the state and have on file a copy of the records with Healing Hand Healthcare LLC.

You also acknowledge that this data will be attached to the chart at the time of the visit and will be used as a direct reflection of symptoms experienced by the patient, and not by the one signing the form. The information is to be presented as subjective data which will be used at the time of the visit to originate talking points to better support and formulate a plan-of-care for treatment measures.

This information will not be given out without legal release from the patient or legal representative at any time.

Patient Signature

Signature _____ Date _____

Healing Hand Healthcare LLC

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Guardian or Authorized Representative Signature

Signature _____ Date _____

FOR PHYSICIAN USE ONLY

Evaluation: _____

Notes:
