

# PHQ-9 modified for Adolescents (PHQ-A)

Name: \_\_\_\_\_ Clinician: \_\_\_\_\_ 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?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

Yes  No

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

**Office use only:**

**Severity score:** \_\_\_\_\_

Johnson JG, Harris ES, Spitzer RL, Williams JB. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002;30(3):196-204. doi:10.1016/s1054-139x(01)00333-0



**Ask the patient:**

- |  |     |    |
|--|-----|----|
| (1) In the past few weeks, have you wished you were dead?  | YES | NO |
| (2) In the past few weeks, have you felt that you or your family would be better off if you were dead? | YES | NO |
| (3) In the past week, have you been having thoughts about killing yourself?                            | YES | NO |
| (4) Have you ever tried to kill yourself?  | YES | NO |
- If yes, how? \_\_\_\_\_ When? \_\_\_\_\_

**If the patient answers yes to any of the above, ask the following question:**

- |  |     |    |
|--|-----|----|
| (5) Are you having thoughts of killing yourself right now? | YES | NO |
|--|-----|----|
- If yes, please describe: \_\_\_\_\_

Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176. doi:10.1001/archpediatrics.2012.1276

## Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score ( <i>add your column scores</i> ) =				

If you checked off any problems, how difficult have these 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 \_\_\_\_\_

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.