Main Line HealthCare
Physician Network

Depression Screening (PHQ-2)

Patient Name:	**DOB:**	**Today's Date:**

Please complete this depression screening prior to seeing your healthcare team. Your answers will help you receive the best care possible.

Over the <u>past 2 weeks</u>, how often have you been bothered by any of the following problems? Circle only one number for each item.

	Not at all	Several Days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Add the number of the marked boxes above and enter your score here. Score:_____

Was your score 3 or more? If so, please answer the questions below. If you score was less than 3, there is no need to answer the questions below.
Be sure to bring this completed screening to your appointment.

	Not at all	Several Days	More than half the days	Nearly everyday
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 fidgety 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 in some way	0	1	2	3

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
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?	0	1	2	3

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