Cheyenne Women's Clinic P.C.

Rene R. Hinkle
MD, FACOG

Jeffrey D. Storey
MD, FACOG

Jacques D. Beveridge
MD, FACOG

Janet L. Anderson
MD, FACOG

LeAyn J. Dillon
DO, FACOG

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____

	Not at All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling asleep 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 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'd be better off dead, or of hurting yourself or others in some way				

10. 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?	Not difficult at All _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

3952 Parkview Dr • Cheyenne, Wyoming 82001 • 307.637.7700 • *info@cheyennewomensclinic.com*