

# A Survey From Your Healthcare Provider — PHQ-9 Modified for Teens

Name \_\_\_\_\_ Clinician \_\_\_\_\_

Medical Record or ID Number \_\_\_\_\_ 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?				

10. In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?  Yes  No

11. 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

12. Has there been a time in the past month when you have had serious thoughts about ending your life?  Yes  No

13. Have you **ever**, in your **whole life**, tried to kill yourself or made a suicide attempt?  Yes  No

FOR OFFICE USE ONLY Score \_\_\_\_\_

Q. 12 and Q. 13 = Y or TS ≥11

## Administering, Scoring and Interpreting the PHQ-9 Screening Questionnaire

### Administering

- The Patient Health Questionnaire Modified for Teens (PHQ-Modified) can be used with patients between the ages of 12 and 18 and takes less than five minutes to complete and score.
- The PHQ-9 Modified can be administered and scored by a nurse, medical technician, physical assistant, physician or other office staff.
- Patients should be left alone to complete the PHQ-9 Modified in a private area, such as an exam room or private area of the waiting room.
- Patients should be informed of their confidentiality rights before the PHQ-9 Modified is administered.
- The American Academy of Pediatrics and U.S. Preventive Service Task Force recommend that depression screening be conducted annually.

### Scoring

- **For every X:**
  - Not all =0
  - Several days=1
  - More than half the days=2
  - Nearly every day=3Add up all “X” ed boxes on the screen
- **Defining a Positive Screen on the PHQ-9 Modified:**
  - Total scores  $\geq 1$  are positive
- **Suicidality:**
  - Regardless of the PHQ-9 Modified total score, endorsement of serious suicidal ideation OR past suicide attempt (question 12 and 13 on the screen) should be considered a positive screen.

### Interpreting the Screening Results

- Patients that score positively on the questionnaire should be evaluated by their primary care provider (PCP) to determine if the depression symptoms they endorsed on the screen are significant, causing impairment and/or warrant a referral to a mental health specialist or follow-up treatment by the PCP.
- It is recommended that the PCP inquire about suicidal thoughts and previous suicide attempts with all patients that score positive, regardless of how they answered these items on the PHQ-9 Modified.
- For patients who score negative on the PHQ-9 Modified, it is recommended that the PCP briefly review the symptoms marked as “more than half days” and “nearly every day” with the patient.
- The questionnaire indicates only the likelihood that a youth is at risk for depression or suicide; its results are not a diagnosis or a substitute for a clinical evaluation.

### Depression Severity

- The overall score on the PHQ-9 Modified provides information about the severity of depression, from minimal depression to severe depression.
- The interview with the patient should focus on their answers to the screen and the specific symptoms with which they are having difficulties.
- Additional questions on the PHQ-9 Modified also explore persistent depressive disorder, impairment of depressive symptoms, recent suicide ideation and previous suicide attempts.
- Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression