Patient Name:

Date of Birth:

Patient Health Questionnaire-Modified for Teens

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, irritable or hopeless?	0	1	2	3
3. Trouble falling asleep, 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, weight loss, 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 like school work, reading, or watching TV?	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

For office coding: ______0______+__________+__________+___________

= Total Score ____________

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

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.