Centre intégré de santé et de services sociaux de la Montérégie-Ouest
Québec

Installation : _____

Dossier : _____

Nom, Prénom : _____

Date de naissance : _____ ☐ F ☐ M
aaaa-mm-jj

NAM : _____ Exp. _____
aaaa-mm

Nom, Prénom de la mère : _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Tool for identifying and assessing the severity of depressive symptoms. **Does not establish a precise diagnosis** and always requires a more thorough assessment of depression symptoms [1].

Please answer each question by circling the statement that best describes your situation.

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, or hopeless *	0	1	2	3
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 [2]	0	1	2	3

*Questions included in the PHQ-2

TOTAL SCORE: sum of the scores obtained for each question _____

If you checked off <u>at least one of the</u> problems identified in this questionnaire, answer the following question: How much did this problem(s) make it difficult for you to work, take care of things at home, or get along with others?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

SECTION RESERVED FOR THE PRACTITIONER

[2] Si l'usager(ère) répond **<u>oui à la question 9</u>**, une évaluation du risque suicidaire ou de l'auto-agressivité par un membre professionnel de la santé ou des services sociaux qualifié est conseillée (psychologue, neuropsychologue, travailleur social, psychiatre, médecin).

Administré par : ☐ Usager(ère) ☐ Proche ☐ Évaluateur du CISSSMO

Nom et titre de l'évaluateur : _____

Signature de l'évaluateur : _____ Date : _____
aaaa-mm-jj

[1]Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.