Simo & Bruck Pediatrics
10115 Forest Hill Blvd.
Wellington, FL 33414

Patient Health Questionnaire-9 Modified for Teens

To be completed by patient (12-19 years)

How often have you been bothered by the following in the past 2 weeks?
Place an **X** in the box that best applies to you.

	0 Not at all	1 Several Days	2 More than Half the Days	3 Nearly Every Day
1. Feeling down, irritable, depressed, 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 like 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 slowing that other people could have noticed? Or- 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?				
In the past year have you felt depressed or sad most days, even if you felt okay sometimes?	Yes	No		
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	Somewhat difficult	Very difficult	Extremely Difficult
Has there been a time in the **past month** when you have had serious thoughts about ending your life?	Yes	No		
Have you **EVER** in your whole life, tried to kill yourself or make a suicide attempt?	Yes	No		

Score: ____________