

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

# PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following

|             |   | 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           | ADULT: Feeling down, depressed, or hopeless<br>PEDIATRIC PATIENT: Feeling irritable or cranky   | 0   | 1            | 2                       | 3                |
| 3           | Trouble falling or staying asleep, 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  | 0   | 1            | 2                       | 3                |
| add columns |   |   |              |                         |                  |
| Total       |   |   |              |                         |                  |
| 10          | If you checked off any problems, how difficult have these problems made it for you to do your work, school work, take care of things at home, or get along with other people. | Not Difficult at all _____<br>Somewhat Difficult _____<br>Very Difficult _____<br>Extremely Difficult _____ |              |                         |                  |

# ESS

Use the following scale to choose the most appropriate number for each situation:

- 0 = would *never* doze or sleep.                      1 = *slight* chance of dozing or sleeping  
 2 = *moderate* chance of dozing or sleeping            3 = *high* chance of dozing or sleeping

|   |       |
|---|-------|
| Sitting and reading   | _____ |
| Watching TV   | _____ |
| Sitting inactive in a public place  | _____ |
| Being a passenger in a motor vehicle for an hour or more  | _____ |
| Lying down in the afternoon   | _____ |
| Sitting and talking to someone  | _____ |
| Sitting quietly after lunch (no alcohol)  | _____ |
| ADULT: Stopped for a few minutes in traffic while driving<br>PEDIATRIC PATIENT: While playing video games | _____ |
| <b>Total score (add the scores up)</b><br>(This is your Epworth score)                                    | _____ |