

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)

Not at all "0" Several days "1" More than half the days "2" Nearly every day "3"

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	0	1	2	3

Add columns: _____ + _____ + _____

Total: _____

If you checked off any problems, 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

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| 10. Have you ever ridden in a car driven by someone (including yourself) who was "HIGH" or had been using alcohol or other drugs? | YES | NO |
| 11. Do you ever use alcohol and other drugs to relax, feel better about yourself to fit in? | YES | NO |
| 12. Do you ever use alcohol or other drugs while you are by yourself? | YES | NO |
| 13. Do you ever forget things you did while using alcohol or other drugs? | YES | NO |
| 14. Do your family or friends ever tell you to cut down on your drinking or drug use? | YES | NO |
| 15. Have you ever gotten into trouble while you were using alcohol or other drugs? | YES | NO |
| 16. Have you ever felt unsafe in a current/past relationship? | YES | NO |
| 17. Do you feel safe in school/work? | YES | NO |
| 18. Any bullying from classmate, teacher, friends or coaches? | YES | NO |
| 19. Does the person you are seeing get angry at you if you do not respond to his/her text messages immediately. | YES | NO |
| 20. Has someone you were going out with ever monitored your phone or text in a controlling way? | YES | NO |