

ACCESS TO CARE - YOUTH

PATIENT NAME: _____

DATE: _____

PHQ-A

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.		Not at all 0	Several days 1	More than half the days 2	Nearly Every Day 3
1.	Feeling down, depressed, irritable, 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 that you are 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 slowly that other people could have noticed? Or the opposite—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?				

TOTAL SCORE: