Pediatric Associates of Whidbey Island, P.S.

Patient Name_______________________________ Date of Birth_______________

Patient Health Questionnaire – Modified for Teens

Over the last 2 weeks, how often have you been bothered by the following problems	Not at all sure	Several days	Over 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 hurting yourself in some way	0	1	2	3
Add the score for each column	0+	+	+	=
TOTAL SCORE				
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

	Yes	No
1. In the ***past few weeks***, have you wished you were dead?	☐	☐
2. In the ***past few weeks***, have you felt that you or your family would be better off if you were dead?	☐	☐
3. In the ***past week,*** have you been having thoughts about killing yourself?	☐	☐
4. Have you ***ever*** tried to kill yourself? If yes, **when** and **how**? ______________________________	☐	☐
5. Are you having thoughts of killing yourself **right now**? If yes, please describe______________________________	☐	☐