RAINBOW CHILDREN'S CLINIC
(12 – 18 YEARS OLD)
PHQ – 9

Name: _____ DOB: _____ Date_____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? Check the specific symptom and put an "X" in the box beneath the answer that best describes how you have been feeling.

	Not At All (0)	Several Days (1)	Nearly Every Day (2)	Every Day (3)
1) FEELING: □ Down □ Depressed □ Irritable □ Hopeless				
2) Little interest or pleasure in doing things? 3) TROUBLE □ Falling Asleep □ Staying Asleep □ Sleeping Too Much				
4) □ Poor Appetite □ Weight Loss □ Over Eating				
5) FEELING □ Tired □ Having Little Energy				
6) FEELING □ Bad About Yourself □ That You Are A Failure □ 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 Slowly □ Being Fidgety, Restless, Moving Around A Lot More Than Usual				
9) □ Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the past year have you felt depressed or sad most days, even if you felt okay sometimes? ____ Yes ____No

11. 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 At all ____ Somewhat Difficult ____Very difficult ____ Extremely Difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? ____ Yes ____No

13. Have you EVER, in you WHOLE LIFE, tried to harm yourself or made a suicidal attempt? ____ Yes ____No

IF YOU HAVE HAD THOUGHTS THAT YOU WOULD BE BETTER OFF DEAD OR OF HURTING YOURSELF IN SOME WAY, PLEASE DISCUSS THIS WITH YOUR HEALTH CARE CLINCIAN, GO TO A HOSPITAL EMERGENCY ROOM, OR CALL 911

CLINIC USE ONLY

____ Severity Score ____ No Risk Factors ____ Counseling Referral ____ Psych Referral

Reviewed by: _____