Transcranial Magnetic Stimulation (TMS)

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Patient Health Questionnaire (PHQ-9)

NAME:____ **DATE**_________________________

Over the last week, how often have you been bothered by any of the following problems?

(Circle your answer)

	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. 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	0	1	2	3
Add columns:	0			
TOTAL:				

Total Score	Depression Severity
0-5	Minimal depression (Remission)
6-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression