PLEASE RETURN FORMS BY:
EMAIL: Cal.Bar@ahs.ca or FAX: (403) 955-8634 or MAIL: 1820 Richmond Rd SW, Calgary, AB, T2T 5C7

Alberta Health Services

Date: _____

Name: _____
Date of birth: _____
Healthcare #: _____

PHQ-9				
Over the last two weeks, how often have you been bothered by the following problems?	**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?	☐	☐	☐	☐
2. Feeling down, depressed or hopeless?	☐	☐	☐	☐
3. Trouble falling or staying asleep, sleeping too much?	☐	☐	☐	☐
4. Feeling tired or having little energy?	☐	☐	☐	☐
5. Poor appetite or overeating?	☐	☐	☐	☐
6. Feeling bad about yourself or that you're a failure, or have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things such as reading the newspaper or watching television?	☐	☐	☐	☐
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 more than usual?	☐	☐	☐	☐
9. Having thoughts that you would be better off dead or hurting yourself in some way?	☐	☐	☐	☐

If you checked off <u>any</u> problems, how <u>difficult</u> 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
☐	☐	☐	☐