The School Board of Brevard County, Florida

PHQ-9 Screening Tool

Your Name: _____ Date: _____

School: _____ Grade: _____

Teacher _____ Age: _____

Please read each question below very carefully and determine which amount of time most closely describes your current situation.

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all (<1 day)**	**Several days**	**More than half the days**	**Nearly every day**
A. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
B. Experienced little interest or pleasure in doing things?	☐	☐	☐	☐
C. Had trouble falling asleep, staying awake or sleeping too much?	☐	☐	☐	☐
D. Experienced poor appetite, weight loss or overeating?	☐	☐	☐	☐
E. Feeling tired or having little energy?	☐	☐	☐	☐
F. Feeling bad about yourself or feeling that you are a failure or that you have let yourself or your family down?	☐	☐	☐	☐
G. Had trouble concentrating on things like school work, reading or watching TV?	☐	☐	☐	☐
H. Felt that you were moving or speaking so slowly that others could have noticed? Or so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
I. Thoughts that you would be better off dead or of hurting yourself in some way?	☐	☐	☐	☐
Column Subtotal (number checked x number in box)	0	1	2	3
			TOTAL	

J. How difficult have the items above made it for you to do your school work, take care of things at home, or get along with other people?

☐ Not Difficult at All ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

Revised 04-19
PL