Garden Psych LLC

36 Ketley Place PHONE: 555-555-5555 E-MAIL: DrMemon@GardenPsych.com

Princeton, NJ 08540 FAX: 555-555-5555

**PHQ-9: Parent Report**

Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rater: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often has your child been bothered by each of the following symptoms during the past 2 weeks. For each symptom, put an "X" in the box beneath the answer that bests describes how your child has been feeling.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **(0)**  **Not At All** | **(1)**  **Several Days** | **(2)**  **More Than Half the Days** | **(3)**  **Nearly Every Day** |
| 1. Feeling down, depressed, irritable or hopeless | 🖵 | 🖵 | 🖵 | 🖵 |
| 2. Little interest or pleasure in doing things? | 🖵 | 🖵 | 🖵 | 🖵 |
| 3. Trouble falling asleep, staying asleep, or sleeping too much? | 🖵 | 🖵 | 🖵 | 🖵 |
| 4. Poor appetite, weight loss, or overeating? | 🖵 | 🖵 | 🖵 | 🖵 |
| 5. Feeling tired, or having little energy? | 🖵 | 🖵 | 🖵 | 🖵 |
| 6. Feeling bad about him/herself - feeling like a failure, or that he/she has let him/herself or the family down? | 🖵 | 🖵 | 🖵 | 🖵 |
| 7. Trouble concentrating on things like school work, reading, or watching TV? | 🖵 | 🖵 | 🖵 | 🖵 |
| 8. Moving or speaking so slowly that other people could have noticed? ...Or the opposite-- being so fidgety or restless that he/she was moving around a lot more than usual? | 🖵 | 🖵 | 🖵 | 🖵 |
| 9. Thoughts that he/she would be better off dead, or of hurting him/herself in some way? | 🖵 | 🖵 | 🖵 | 🖵 |
| In the **past year,** has he/she felt depressed or sad most days, even if he/she felt okay sometimes?  [ ] Yes [ ] No | | | | |
| If he/she is experiencing any of the problems on this form, **how difficult** have these problems made it for him/her to do work, take care of things at home, or get along with other people  [ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult | | | | |

|  |
| --- |
| Has there been a time in the **past month** when he/she has had serious thoughts about ending his/her life?  [ ] Yes [ ] No |
| Has he/she **EVER**, in his/her WHOLE LIFE, tried to kill him/herself or made a suicide 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 Clinician, go to a hospital emergency room or call 911