John L. Birbari, M.D. **Texas Healthcare, P.L.L.C.**

Patient Name: _____ _____ Date: _____

Patient Health Questionnaire

Over the last two weeks, have you been bothered by any of the following problems?

1) Little interest or pleasure in doing things no yes how often? _____

2) Feeling down, depressed, or hopeless no yes how often? _____

3) Feeling badly about yourself, that you are no yes how often? _____
a failure or have let yourself or family down

4) Trouble concentrating on things such as no yes how often? _____
reading , or watching television

5) Moving or speaking so slowly that others no yes how often? _____
have noticed

6) Feeling very fidgety or restless no yes how often? _____

7) Trouble falling or staying asleep or, no yes how often? _____
sleeping too much

8) Thoughts that you would be better off no yes how often? _____
if you were dead, or of hurting yourself in some way

9) Feeling tired or having little energy no yes how often? _____

10) If you answered yes to any of the above; 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?

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11) Do you regularly exercise? no yes how often? _____

If yes, what type of exercise? _____

12) Do you feel that you are eating a healthy diet? no yes

If you answered no, what changes do you think you could or should make to improve your diet?

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13) Do you have any specific goals, or changes you would like to make to improve your health?

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