Patient name			
MHN	DOB	Age	Gender

Patient Health Screening (PHQ-9)/Columbia-Suicide Severity Rating Scale (Screen Version)

Psychiatric/MH Assessment

Over the last 2 weeks, how often have you been bothered by any of the following problems: *Check (✔) your answer.*	**Not At All** *(0)*	**Several Days** *(1)*	**More Than Half the Days** *(2)*	**Nearly Every Day** *(3)*
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead or of hurting yourself in some way **If anything but a 0 score on this question, complete back/page 2**				

If you checked off any problems, 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:

☐ Not difficult at all ☐ Somewhat difficult
☐ Very difficult ☐ Extremely difficult

For office coding 0 + _____ + _____ + _____

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

= TOTAL SCORE _____

Depression Screening Plan:

☐ Monitor condition ☐ Continue current treatment ☐ Contact your current Behavioral Health provider
☐ Acute intervention ☐ Pharmacology intervention ☐ Clinical impression does not indicate depression
☐ Continue treatment in Behavioral Health ☐ Refer to Behavioral Health ☐ Schedule follow-up with primary care provider

Comment _____

Signature/Title _____ Date (m/d/y) ____ /____ /____ Time _____

Patient Health Screening (PHQ-9)/Columbia-Suicide Severity Rating Scale (Screen Version)

Psychiatric/MH Assessment (Continued)

Patient name	MHN	DOB	Age	Gender

	In The Past Month	
Answer Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts about killing yourself?***		
If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6 ←		
3) ***Have you thought about how you might do this?***		
4) ***Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?***		
5) ***Have you started to work out or worked out the details of how to kill yourself?*** ***Do you intend to carry out this plan?***		
	In the Past 3 Months	
6) ***Have you done any of the following?*** ***Attempted to kill yourself even if ending your life was only part of your motivation*** ***Started to do something to end your life but someone or something stopped you before you actually did anything*** ***Started to do something to end your life but you stopped yourself before you actually did anything*** ***Taken any steps towards making a suicide attempt or preparing to kill yourself*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. ***In your entire lifetime, how many times have you done any of these things?***		

Signature/Title _____ Date (m/d/y) ____ /____ /____ Time _____