

Depression Screening (PHQ-C)

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

 Is your child currently: ☐ on medication for depression ☐ not on medication for depression ☐ not sure
☐ in counseling

Over the last 2 weeks, how often has your child been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, irritable, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling asleep, staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about him or herself — or that he or she is a failure, or have let him or herself or family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things like school work, reading, or watching TV	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed, or the opposite — being so fidgety or restless that he or she has been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that he or she would be better off dead, or hurting him or herself in some way	☐ 0	☐ 1	☐ 2	☐ 3

 10. If your child is experiencing any of the problems on this form, how **difficult** have these problems made it for your child to do his or her work, take care of things at home, or get along with other people?

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

 11. In the **past year**, has your child seemed depressed or sad most days, even if he or she seems to feel okay sometimes? ☐ Yes ☐ No

For office use only:

Symptom score (total # of answers in shaded areas) _____

Severity score (total points from all questions) _____

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