Intermountain Health

Intermountain Behavioral Health

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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