Name: **DOB:**

WORKSITE+WELLNESS
OCCUPATIONAL HEALTH SERVICES, LLC

PQH9 Depression Screening Questionnaire

If you struggle with depression, or have been concerned about mood changes recently, please complete the following depression screening questionnaire. This questionnaire will assist your provider during the scheduled examination appointment. ***Please know, all information on your questionnaire is strictly confidential and can not be used to remove you from duty.*** If you do not struggle with depression or do not feel comfortable sharing this information, please skip this questionnaire.

Over the last two (2) weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total each column				

Add all columns together for total_____

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