

BEACON MENTAL HEALTH

The Patient Health Questionnaire (PHQ-9)

Name _____

Date of Visit _____

What brings you in today? _____

Over the past 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
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed 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 yourself- or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	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 you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

10. If you checked off any problems, how difficult have those 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

MEDICATION ASSISTED TREATMENT SCREENING

Do you use opioids (such as heroin, fentanyl, Oxycontin, Hydrocodone, Percocet, morphine, suboxone, etc.)? _____

Do you want medication to assist with your sobriety? Yes No N/A

CLIENT NAME: _____

CLIENT ID#: _____