

**Patient Health Questionnaire****Patient Name: jonny rhea**

\* Over the past two 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	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed, or hopeless	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling asleep, staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Feeling bad about yourself - or that you're a failure or have let yourself or your family down	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
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	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoughts that you would be better off dead or of hurting yourself in some way	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

\* If you checked off any problems, how difficult have those problems made it for you to:

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
Do your work, take care of things at home, or get along with other people?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\* Are you currently smoking?

Yes

No