PHQ-4 — Ultra-Brief Anxiety & Depression Screener

Time frame: *Over the last 2 weeks*
Use case: First contact / onboarding / quick triage

Instruction shown to user:

Please read each statement and choose the option that best describes how often you experienced the problem over the **past two weeks**.

Common Options & Weights (for all questions)

- **0** – I did not experience this at all.
- **1** – I experienced this on several days.
- **2** – I experienced this on more than half of the days.
- **3** – I experienced this nearly every day.

Q1. Feeling nervous, anxious, or on edge *(Anxiety)*

- **0** – I did not feel nervous, anxious, or on edge at all.
- **1** – I felt nervous, anxious, or on edge on several days.
- **2** – I felt nervous, anxious, or on edge on more than half of the days.
- **3** – I felt nervous, anxious, or on edge nearly every day.

Q2. Not being able to stop or control worrying *(Anxiety)*

- **0** – I was able to control my worrying without difficulty.
- **1** – I had trouble controlling my worrying on several days.
- **2** – I had trouble controlling my worrying on more than half of the days.
- **3** – I had trouble controlling my worrying nearly every day.

Q3. Little interest or pleasure in doing things *(Depression)*

- **0** – I did not lose interest or pleasure in activities.
- **1** – I lost interest or pleasure on several days.
- **2** – I lost interest or pleasure on more than half of the days.
- **3** – I lost interest or pleasure nearly every day.

Q4. Feeling down, depressed, or hopeless *(Depression)*

- **0** – I did not feel down, depressed, or hopeless at all.
- **1** – I felt down, depressed, or hopeless on several days.
- **2** – I felt down, depressed, or hopeless on more than half of the days.
- **3** – I felt down, depressed, or hopeless nearly every day.

Scoring Logic (AI-Ready)

Total PHQ-4 Score

Total Score = Q1 + Q2 + Q3 + Q4

Range = 0 – 12

Subscale Scores (IMPORTANT)

Anxiety Score = Q1 + Q2 (0–6)

Depression Score = Q3 + Q4 (0–6)

Interpretation Thresholds

Overall PHQ-4 Score

Score	Distress Level
0–2	None
3–5	Mild
6–8	Moderate
9–12	Severe

Subscale Interpretation

- **Anxiety ≥ 3** → Anxiety symptoms flagged
- **Depression ≥ 3** → Depressive symptoms flagged

Either flag triggers **deeper assessment** (GAD-7 / PHQ-9).

AI Decision Rules (Onboarding Logic)

- **PHQ-4 < 3** → Continue normal onboarding
- **PHQ-4 ≥ 3** → Recommend full screening
- **PHQ-4 ≥ 6** → Prioritize mental health check-in
- **Depression subscale ≥ 3** → Launch PHQ-9
- **Anxiety subscale ≥ 3** → Launch GAD-7

Safety & Compliance Notes

- PHQ-4 is a **screening tool**, not a diagnosis
- No suicide item → **Low immediate risk**, safe for onboarding
- Designed for **speed + minimal user fatigue**

Panel-Ready One-Liner

"PHQ-4 allows our AI to quickly screen for anxiety and depressive symptoms during onboarding and intelligently route users to deeper assessments only when needed."