

Patient Health Questionnaire – 4 (PHQ-4)

Name: _____

Date of Birth: _____ Today's Date: _____

Over the last 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

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>