

We know that many patients experiencing infertility frequently report feeling stressed or sad. We are interested in how you are feeling. Please complete this questionnaire and return it with the *Patient Intake History*. One of our Women's Health counselors will review the information that you provide. If they have further questions or feedback they will contact you via phone. Please provide the best number(s) to contact you at below.

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				

10. 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 \_\_\_\_\_

For Office Use Only: Date \_\_\_\_\_ Score \_\_\_\_\_ WBHS Initials \_\_\_\_\_

