

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or 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 are 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

FOR OFFICE CODING   0   +        +        +       

=Total Score:       

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

**COLUMBIA-SUICIDE SEVERITY RATING SCALE**  
*Screen with Triage Points for Outpatient/Ambulatory*

Ask questions that are in bold and underlined.	Past month	
	YES	NO
<b>Ask Questions 1 and 2</b>		
<b>1) <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u></b>		
<b>2) <u>Have you had any actual thoughts of killing yourself?</u></b>		
<b>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</b>		
<b>3) <u>Have you been thinking about how you might do this?</u></b> <i>e.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."</i>		
<b>4) <u>Have you had these thoughts and had some intention of acting on them?</u></b> <i>as opposed to "I have the thoughts but I definitely will not do anything about them."</i>		
<b>5) <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u></b>		
<b>6) <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u></b>  Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	<b>Lifetime</b>	
	<b>Past 3 Months</b>	
<b>If YES, ask: <u>Was this within the past 3 months?</u></b>		

**Response Protocol to C-SSRS Screening**

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Behavioral Health Consultation and Patient Safety Precautions
Item 5 Behavioral Health Consultation and Patient Safety Precautions
Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

# Patient Safety Plan Template

## Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Step 3: People and social settings that provide distraction:

1. Name \_\_\_\_\_ Phone \_\_\_\_\_
2. Name \_\_\_\_\_ Phone \_\_\_\_\_
3. Place \_\_\_\_\_ 4. Place \_\_\_\_\_

## Step 4: People whom I can ask for help:

1. Name \_\_\_\_\_ Phone \_\_\_\_\_
2. Name \_\_\_\_\_ Phone \_\_\_\_\_
3. Name \_\_\_\_\_ Phone \_\_\_\_\_

## Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name \_\_\_\_\_ Phone \_\_\_\_\_  
Clinician Pager or Emergency Contact # \_\_\_\_\_
2. Clinician Name \_\_\_\_\_ Phone \_\_\_\_\_  
Clinician Pager or Emergency Contact # \_\_\_\_\_
3. Local Urgent Care Services \_\_\_\_\_  
Urgent Care Services Address \_\_\_\_\_  
Urgent Care Services Phone \_\_\_\_\_
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

## Step 6: Making the environment safe:

1. \_\_\_\_\_
2. \_\_\_\_\_

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The one thing that is most important to me and worth living for is:

\_\_\_\_\_