**Appendix 1. Patient Health Questionnaire (PHQ-9) scoring sheet**

**Patient ID**: \_\_ \_\_ - \_\_- \_\_ \_\_ \_\_ \_\_ (Country-Site-Number)

**Visit Date**: \_\_ \_\_- \_\_ \_\_ \_\_-\_\_ \_\_ \_\_ \_\_ (dd-mmm-year)

|  |
| --- |
|  |
| Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and check your response. |
|  |
|  | Notat all | Severaldays | More than half the days | Nearlyevery day |
|  | 0 | 1 | 2 | 3 |
| 1. Little interest or pleasure in doing things
 |  |  |  |  |
| 1. Feeling down, depressed, or hopeless
 |  |  |  |  |
| 1. Trouble falling asleep, staying asleep, or sleeping too much
 |  |  |  |  |
| 1. Feeling tired or having little energy
 |  |  |  |  |
| 1. Poor appetite or overeating
 |  |  |  |  |
| 1. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
 |  |  |  |  |
| 1. Trouble concentrating on things such as reading the newspaper or watching television
 |  |  |  |  |
| 1. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
 |  |  |  |  |
| 1. Thinking that you would be better off dead or that you want to hurt yourself in some way
 |  |  |  |  |
| Total score |  |