Central East REGIONAL CARDIOVASCULAR REHAB

Name: _____ **Date of Birth: (**DD/MM/YYYY**)**_____

Patient Health Questionnaire-4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by the following problems? *(Circle your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

Please check you have answered all the questions

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