

PHQ-9 Documentation Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

The PHQ-9 is a nine-item, public-domain depression severity measure scored 0 to 27 over the past two weeks. The score is a screen and a severity trend, never a stand-alone diagnosis, and item 9 is a safety flag that starts a direct inquiry, not a completed suicide-risk assessment.

Form, mode, and language name the exact instrument

Do: record PHQ-9 vs PHQ-2 vs PHQ-8 vs teen version, plus mode (paper, portal, interview) and language.

Pitfall: "PHQ positive" with no form named; denominators and safety content differ across the family.

Total and severity band always over 27

Do: write the fraction and band: 0-4 minimal, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe.

Pitfall: "14/30" totals; the functional item is unscored and never joins the arithmetic.

Item 9, separately, every time flag, not verdict

Do: record the 0-3 answer even at zero; any nonzero response gets a same-visit inquiry, risk formulation, and disposition.

Pitfall: reflex ED referral for any endorsement, or a zero cited as the reason risk inquiry stopped.

Functional interference unscored, still recorded

Do: record the patient's answer (not difficult through extremely difficult) beside the total.

Pitfall: dropping it; it is the instrument's only direct read on impairment.

Prior score and change points and percent

Do: name the baseline and date, then both numbers; about six points clears measurement error, 50% is response, below 5 is remission.

Pitfall: the five-point reflex, or "improved" with no baseline named.

Interpretation sentence screen, not diagnosis

Do: state the result as a severity screen in clinical context; after the interview, "consistent with" is the defensible verb.

Pitfall: promoting a band to a diagnosis; "moderate depressive symptom severity" is the accurate phrase.

Plan linkage and next measurement no orphaned scores

Do: state what continues or changes because of the result, and date the next administration by treatment phase.

Pitfall: a score with no plan sentence; it documents administration, not care.

Before the note is signed

- ☐ Exact form named, not just "PHQ"
- ☐ Language and administration mode recorded
- ☐ Total written over 27 with the published band
- ☐ Item 9 recorded; any nonzero assessed same visit
- ☐ Functional item recorded, kept out of the total
- ☐ Change stated in points and percent vs named baseline
- ☐ Plan linkage and next measurement date written

Drafting with AI

Give it the score facts: form, total, item 9, functional answer, prior score and date, and the plan decision.

"Draft PHQ-9 documentation: 14/27 by portal today, item 9 = 1, prior 20/27 four weeks ago, continuing weekly therapy, prescriber review next week."

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

0 to 27

five severity bands

2 to 6 chart lines

typical documentation

Under 3 minutes

patient completion

Public domain

free to reproduce

PHQ-9 Documentation Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Practice/clinic: Patient (initials): Date administered:

Form: PHQ-9 / PHQ-8 / teen version: Language: Mode: paper / portal / interview:

Score

Total ___/27 · severity band: minimal, mild, moderate, moderately severe, severe · notable individual items

Item 9 response and same-visit follow-up

Response 0-3, recorded even at zero · if nonzero: passive vs active ideation, plan, intent, preparatory behavior, history, protective factors · risk formulation with reasoning · proportionate disposition · safety plan updated

Functional interference (unscored)

Patient's answer: not difficult / somewhat / very / extremely difficult · kept out of the total

Prior score and change

Baseline score and date · change in points and percent · construct claimed: beyond measurement error (about six points) / response at 50% / remission below 5

Interpretation

Severity screen result in clinical context · screen, not a stand-alone diagnosis · discrepancies with presentation explained

Plan linkage and next measurement

What continues, changes, or is deferred and why · next administration date and reason · registry or quality program this result feeds

Clinician (name and credentials): Signature: Date: