Community Care Family Medicine
5 Southside Drive • Suite 204
Clifton Park, New York 12065
371-9355

Name: ______________________________

Date of Birth: ________/________/________
Month Date Year

GERIATRIC DEPRESSION SCALE

	YES	NO
1. Are you basically satisfied with your life?	☐	☐
2. Have you dropped many of your activities and interests?	☐	☐
3. Do you feel that your life is empty?	☐	☐
4. Do you often get bored?	☐	☐
5. Are you in good spirits most of the time?	☐	☐
6. Are you afraid that something bad is going to happen to you?	☐	☐
7. Do you feel happy most of the time?	☐	☐
8. Do you often feel helpless?	☐	☐
9. Do you prefer to stay home rather than going out and doing new things?	☐	☐
10. Do you feel you have more problems with memory than most?	☐	☐
11. Do you think it is wonderful to be alive now?	☐	☐
12. Do you feel pretty worthless the way you are now?	☐	☐
13. Do you feel full of energy?	☐	☐
14. Do you feel that your situation is hopeless?	☐	☐
15. Do you think that most people are better off than you are?	☐	☐