

Name: _____ Date of Birth: _____ Today's Date: _____

During the past two weeks, **how often** have you been bothered by any of the following problems?

	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. Poor appetite, weight loss, or overeating	0	1	2	3
5. Feeling tired or having little energy	0	1	2	3
6. Feeling bad about yourself – or feeling that you are a failure, or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, like 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	0	1	2	3

add columns _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

PLEASE CALCULATE TOTAL _____

10. 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

Provider initials _____