DEPRESSION SCALE

Patient Name: ______________________________

Date: ____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Circle to indicate your answer.

	Not at all	Several Days	More Than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feelings down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
COLUMN TOTALS	_____ +	_____+	_____+	____

Total = ____________

Do you have any suicidal thoughts? _____yes ______no

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