

Patient Name: _____ Provider _____ Date: _____

1. Over the last 2 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 |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | 0 | 1 | 2 | 3 |
| a. Little interest or pleasure in doing things | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Feeling down, depressed, or hopeless | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Trouble falling/staying asleep, sleeping too much | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Feeling tired or having little energy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Poor appetite or overeating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Trouble concentrating on things, such as reading the newspaper or watching television. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. 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. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Thoughts that you would be better off dead or of hurting yourself in some way. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. If you checked off any problem on this questionnaire so far, 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 |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. If these problems have caused you difficulty, have they caused you difficulty for two years or more?

_____ Yes, I have had difficulty with these problems for two years or more.

_____ No, I have not had difficulty with these problems for two years or more.

Number of Symptoms: _____

Total Score for first 9 Questions: _____

Function Score (Question 2): _____

A Self-Care Screening Survey for Depression Awareness

A) During the past month have you **often** been bothered by:

- 1) little interest or pleasure in doing things
- 2) feeling down, depressed, or hopeless?

B) If you answered yes to either 1 or 2 above complete the questionnaire on the opposite side of this sheet.

