

## Depression Questionnaire

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

- 0) Not at all    1) Several days    2) More than half the days    3) Nearly every day

Little interest or pleasure in doing things

Feeling down, depressed, or hopeless

Trouble falling or staying asleep, or sleeping too much

Feeling tired or having little energy

Poor appetite or overeating

Feeling bad about yourself – or that you are a failure or have let yourself or your family down

Trouble concentrating on things, such as reading the newspaper or watching television

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

Thoughts that you would be better off dead or of hurting yourself in some way

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? (Check only one)

Not at all difficult

Somewhat difficult

Very difficult

Extremely difficult

### Form Instructions

Please return your completed form to Sharp Rees-Stealy in one of the following ways:

- Email\* it to [srs.forms@sharp.com](mailto:srs.forms@sharp.com)
- Bring it with you at the time of your appointment

\*Your privacy is important to us. Please use the email option if you have a personal email account that only you can access.

For physician use:

Total score = \_\_\_\_\_ (5-9/10-14/15-19/20-)