USF Mood & Anxiety Disorders Program

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)(QIDS-SR$_{16}$)

Please circle the one response to each item that best describes you for the past **seven days**.

1. Falling Asleep:

   0 I never take longer than 30 minutes to fall asleep.
   1 I take at least 30 minutes to fall asleep, less than half the time.
   2 I take at least 30 minutes to fall asleep, more than half the time.
   3 I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep During the Night:

   0 I do not wake up at night.
   1 I have a restless, light sleep with a few brief awakenings each night.
   2 I wake up at least once a night, but I go back to sleepeasily.
   3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. Waking Up Too Early:

   0 Most of the time, I awaken no more than 30 minutes before I need to get up.
   1 More than half the time, I awaken more than 30 minutes before I need to get up.
   2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
   3 I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping Too Much:

   0 I sleep no longer than 7-8 hours/night, without nappingduring the day.
   1 I sleep no longer than 10 hours in a 24-hour period including naps.
   2 I sleep no longer than 12 hours in a 24-hour period including naps.
   3 I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling Sad:

   0 I do not feel sad
   1 I feel sad less than half the time.
   2 I feel sad more than half the time.
   3 I feel sad nearly all of the time.

6. Decreased Appetite:

   0 There is no change in my usual appetite.
   1 I eat somewhat less often or lesser amounts of food than usual.
   2 I eat much less than usual and only with personal effort.
   3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

7. Increased Appetite:

   0 There is no change from my usual appetite.
   1 I feel a need to eat more frequently than usual.
   2 I regularly eat more often and/or greater amounts of food than usual.
   3 I feel driven to overeat both at mealtime and between meals.

8. Decreased Weight (Within the Last Two Weeks):

   0 I have not had a change in my weight.
   1 I feel as if I've had a slight weight loss.
   2 I have lost 2 pounds or more.
   3 I have lost 5 pounds or more.

9. Increased Weight (Within the Last Two Weeks):

   0 I have not had a change in my weight.
   1 I feel as if I've had a slight weight gain.
   2 I have gained 2 pounds or more.
   3 I have gained 5 pounds or more.

10. Concentration/Decision Making:

    0 There is no change in my usual capacity to concentrate or make decisions.
    1 I occasionally feel indecisive or find that my attention wanders.
    2 Most of the time, I struggle to focus my attention or to make decisions.
    3 I cannot concentrate well enough to read or cannot make even minor decisions.

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11. View of Myself:

    0 I see myself as equally worthwhile and deserving as other people.
    1 I am more self-blaming than usual.
    2 I largely believe that I cause problems for others.
    3 I think almost constantly about major and minor defects in myself.

12. Thoughts of Death or Suicide:

    0 I do not think of suicide or death.
    1 I feel that life is empty or wonder if it's worth living.
    2 I think of suicide or death several times a week for several minutes.
    3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

13. General Interest:

    0 There is no change from usual in how interested I am inother people or activities.
    1 I notice that I am less interested in people or activities.
    2 I find I have interest in only one or two of my formerlypursued activities.
    3 I have virtually no interest in formerly pursued activities.

14. Energy Level:

    0 There is no change in my usual level of energy.
    1 I get tired more easily than usual.
    2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking or going to work).
    3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down:

    0 I think, speak, and move at my usual rate of speed.
    1 I find that my thinking is slowed down or my voice sounds dull or flat.
    2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
    3 I am often unable to respond to questions without extreme effort.

16. Feeling restless:

    0 I do not feel restless.
    1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.
    2 I have impulses to move about and am quite restless.
    3 At times, I am unable to stay seated and need to pace around.

To Score:

1. Enter the highest score on any 1 of the 4 sleep items (1-4) _____
2. Item 5 _____
3. Enter the highest score on any 1 appetite/ weight item (6-9) _____
4. Item 10 _____
5. Item 11 _____
6. Item 12 _____
7. Item 13 _____
8. Item 14 _____
9. Enter the highest score on either of the 2 psychomotor items (15 and 16) _____

TOTAL SCORE (Range 0-27) _____

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Generalized Anxiety Disorder 7 (GAD 7)

Over the last 2 weeks how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add columns				
			Total score	

Do you suffer from panic attacks? Yes No

Number per month? _____/month

Do you avoid leaving your house/apartment? Yes No

Do you suffer from nightmares from a traumatic event? Yes No

Number per month? _____/month

Do you suffer from flashbacks of a traumatic event? Yes No

Number per month? _____/month

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
	☐	☐	☐	☐

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Concise Health Risk Tracking (CHRT) – Self-Rated

For the following questions, please rate the extent to which each of the following statements describes how you have been feeling or acting in the past week.

For example, if you feel the statement very accurately describes how you have been feeling in the past week, you would give a rating of "Strongly Agree." If you feel the statement is not at all how you have been feeling in the past week, you would give a rating of "Strongly Disagree."

		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1.	There is no one I can depend on.	☐	☐	☐	☐	☐
2.	It seems as if I can do nothing right.	☐	☐	☐	☐	☐
3.	Everything I do turns out wrong.	☐	☐	☐	☐	☐
4.	The people I care the most for are gone.	☐	☐	☐	☐	☐
5.	I have been having thoughts of killing myself.	☐	☐	☐	☐	☐
6.	I have thoughts about how I might kill myself.	☐	☐	☐	☐	☐
7.	I have a plan to kill myself.	☐	☐	☐	☐	☐

CHRT Behavior Module – Self-Rated

		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1.	I wish my suffering could just all be over.	☐	☐	☐	☐	☐
2.	I wish I could just go to sleep and not wake up.	☐	☐	☐	☐	☐
3.	I took steps towards killing myself.	☐	☐	☐	☐	☐
4.	I started to kill myself but stopped before I did anything.	☐	☐	☐	☐	☐
5.	I tried to kill myself.	☐	☐	☐	☐	☐
6.	I hurt myself on purpose, but was not trying to kill myself.	☐	☐	☐	☐	☐

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Concise Associated Symptoms Tracking – Self-report scale

CAST-SR

Please read this series of statements and rate the extent to which each of the statements describes how you have been feeling or acting in the **past 24 hours**.

For example, if you feel the statement very accurately describes how you have been feeling in the past 24 hours, you would give a rating of "Strongly Agree." If you feel the statement is not at all how you have been feeling in the past 24 hours, you would give a rating of "Strongly Disagree."

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I feel anxious all the time.	☐	☐	☐	☐	☐
2. I have been feeling really good lately.	☐	☐	☐	☐	☐
3. I feel as if I am going to have a heart attack.	☐	☐	☐	☐	☐
4. I wish people would just leave me alone.	☐	☐	☐	☐	☐
5. I have been having more trouble sleeping than usual.	☐	☐	☐	☐	☐
6. I am feeling restless, as if I have to move constantly.	☐	☐	☐	☐	☐
7. I suddenly feel very confident.	☐	☐	☐	☐	☐
8. I am more talkative than normal	☐	☐	☐	☐	☐
9. I feel very uptight.	☐	☐	☐	☐	☐
10. I find myself saying or doing things without thinking	☐	☐	☐	☐	☐
11. I feel very tense and I cannot relax.	☐	☐	☐	☐	☐
12. I can feel my heart racing.	☐	☐	☐	☐	☐
13. Lately everything seems to be annoying me.	☐	☐	☐	☐	☐
14. I slept very little last night.	☐	☐	☐	☐	☐
15. I cannot sit still.	☐	☐	☐	☐	☐
16. I find people get on my nerves easily.	☐	☐	☐	☐	☐
17. I have been having lots of great ideas.	☐	☐	☐	☐	☐

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Frequency and Intensity of Burden of Side Effects Rating (FIBSR)

INSTRUCTIONS: Select the best response for the following three questions.

1. Choose the response that best describes the *frequency (how often)* of the side effects of the treatment you have taken within the past week **for your mood or anxiety disorder**. Do not rate side effects if you believe they are due to treatments that you are taking for medical conditions other than depression. Rate the frequency of these side effects for the past week.

No side effects	Present 10% of the time	Present 25% of the time	Present 50% of the time	Present 75% of the time	Present 90% of the time	Present all of the time
❑	❑	❑	❑	❑	❑	❑
0	1	2	3	4	5	6

2. Choose the response that best describes the *intensity (how severe)* of the side effects that you believe are due to the treatment you have taken within the last week **for your mood or anxiety disorder**. Rate the intensity of the side effect(s), when they occurred, over the last week.

No side effects	Trivial	Mild	Moderate	Marked	Severe	Intolerable
❑	❑	❑	❑	❑	❑	❑
0	1	2	3	4	5	6

3. Choose the response that best describes the *degree* to which treatment side effects that you have had over the last week have *interfered* with your day to day functions.

No impairment	Minimal impairment	Mild impairment	Moderate impairment	Marked impairment	Severe impairment	Unable to function due to side effects
❑	❑	❑	❑	❑	❑	❑
0	1	2	3	4	5	6

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Medication Compliance and Side Effects Questionnaire

How frequently do you **NOT** take your medication?

Medication	How often?	Reason for missed doses

What Side Effects from medications/treatments are you experiencing?

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Work and Social Adjustment Scale

Rate each of the following questions on a 0 to 8 scale: 0 indicates no impairment at all and 8 indicates very severe impairment. Please circle your responses below.

1. Because of my depression, my ability to work is impaired. 0 means not at all impaired and 8 means very severely impaired to the point I can't work.

   0 1 2 3 4 5 6 7 8

2. Because of my depression, my home management (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired. 0 means not at all impaired and 8 means very severely impaired.

   0 1 2 3 4 5 6 7 8

3. Because of my depression, my social leisure activities (with other people, such as parties, bars, clubs, outings, visits, dating, home entertainment) are impaired. 0 means not at all impaired and 8 means very severely impaired.

   0 1 2 3 4 5 6 7 8

4. Because of my depression, my private leisure activities (done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired. 0 means not at all impaired and 8 means very severely impaired.

   0 1 2 3 4 5 6 7 8

5. Because of my depression, my ability to form and maintain close relationships with others, including those I live with, is impaired. 0 means not at all impaired and 8 means very severely impaired.

   0 1 2 3 4 5 6 7 8

WSAS Total _____