



Name (please print) _____ Date of Birth _____ ID# _____

Today's Date _____

Please answer the following questions:

Over the last 2 weeks, how often have you been bothered by any of the following problems: (Check box)

	Not at all 0	Several Days 1	More than half the days 2	Nearly every day 3
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				
Thoughts that you would be better off dead or of hurting yourself in some way				

Thank you for completing this questionnaire.