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Patient or Client Identifier:
|__|__|__|__|__|__|__|__|__|__|

Surname:

Other names:

Date of Birth: Sex:

___ ___ / ___ ___ / ___ ___ ___ ___ Male ☐1 Female ☐2

Address:

The following questions ask about how you have been feeling during the **past 30 days**. For each question, please circle the number that best describes how often you had this feeling.

Q1. During that month, how often did you feel …	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
a. … tired out for no good reason?	**1**	**2**	**3**	**4**	**5**
b. …nervous?	**1**	**2**	**3**	**4**	**5**
c. …so nervous that nothing could calm you down?	**1**	**2**	**3**	**4**	**5**
d. …hopeless?	**1**	**2**	**3**	**4**	**5**
e. …restless or fidgety?	**1**	**2**	**3**	**4**	**5**
f. …so restless that you could not sit still?	**1**	**2**	**3**	**4**	**5**
g. …depressed?	**1**	**2**	**3**	**4**	**5**
h. …so depressed that nothing could cheer you up?	**1**	**2**	**3**	**4**	**5**
i. …that everything was an effort?	**1**	**2**	**3**	**4**	**5**
j. …worthless?	**1**	**2**	**3**	**4**	**5**

Please turn over the page to continue

Q2. The last ten questions asked about feelings that might have occurred during the past 30 days. Taking them altogether, did these feelings occur More often in the past 30 days than is usual for you, about the same as usual, or less often than usual? (If you never have any of these feelings, circle response option "4.")

More often than usual			About the same as usual	Less often than usual		
A lot	Some	A little		A little	Some	A lot
1	2	3	4	5	6	7

The next few questions are about how these feelings may have affected you in the past 30 days. You need not answer these questions if you answered "None of the time" to **all** of the ten questions about your feelings.

Q3. During the past 30 days, how many days out of 30 were you totally unable to work or carry out your normal activities because of these feelings?

_____ **(Number of days)**

Q4. **Not counting the days you reported in response to Q3**, how many days in the past 30 were you able to do only half or less of what you would normally have been able to do, because of these feelings?

_____ **(Number of days)**

Q5. During the past 30 days, how many times did you see a doctor or other health professional about these feelings?

_____ **(Number of times)**

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
Q6.	During the past 30 days, how often have physical health problems been the main cause of these feelings?	**1**	**2**	**3**	**4**	**5**

Thank you for completing this questionnaire.