



DEPRESSION QUESTIONNAIRE

Name: _____

Date: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?
(Please check all that apply)

	Not at all	Several days	More than half the days	Nearly every day
1. Poor appetite or overeating.	0	1	2	3
2. Feeling tired or having little or energy.	0	1	2	3
3. Feeling down, depressed, or hopeless.	0	1	2	3
4. Little interest or joy in doing things.	0	1	2	3
5. Trouble falling or staying sleep, or sleeping too much.	0	1	2	3
6. Thoughts that you would be better off hurting yourself.	0	1	2	3
7. Trouble focusing on things, such as reading the newspaper or watching television.	0	1	2	3
8. Feeling bad about yourself –or that you are a failure or have let yourself or your family down.	0	1	2	3
9. Moving or speaking so slowly that other people could have noticed. Or the opposite – been so nervous or restless that you have been moving around a lot more than usual.	0	1	2	3
Add Columns	0	+	+	+
(Note to health care professionals) For interpretation of TOTAL, please refer to the scoring card.	Total Score =			
10. If you checked off any problems, how tough 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			