Name_____ Date_____

DEPRESSION SCALE

INSTRUCTIONS

This questionnaire includes questions about symptoms of depression. For each item please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

RATING GUIDELINES

0=not at all true (0 days)
1=rarely true (1-2 days)
2=sometimes true (3-4 days)
3=often true (5-6 days)
4=almost always true (every day)

During the PAST WEEK, INCLUDING TODAY....

1.	I felt sad or depressed	0	1	2	3	4
2.	I was not as interested in my usual activities	0	1	2	3	4
3.	My appetite was poor and I didn't feel like eating	0	1	2	3	4
4.	My appetite was much greater than usual	0	1	2	3	4
5.	I had difficulty sleeping	0	1	2	3	4
6.	I was sleeping too much	0	1	2	3	4
7.	I felt very fidgety, making it difficult to sit still	0	1	2	3	4
8.	I felt physically slowed down, like my body was stuck in mud	0	1	2	3	4
9.	My energy level was low	0	1	2	3	4
10.	I felt guilty	0	1	2	3	4
11.	I thought I was a failure	0	1	2	3	4
12.	I had problems concentrating	0	1	2	3	4
13.	I had more difficulties making decisions than usual	0	1	2	3	4
14.	I wished I was dead	0	1	2	3	4
15.	I thought about killing myself	0	1	2	3	4
16.	I thought that the future looked hopeless	0	1	2	3	4

17. Overall, how much have symptoms of depression interfered with or caused difficulties in your life during the past week?
    0) not at all
    1) a little bit
    2) a moderate amount
    3) quite a bit
    4) extremely

18. How would you rate your overall quality of life during the past week?
    0) very good, my life could hardly be better
    1) pretty good, most things are going well
    2) the good and bad parts are about equal
    3) pretty bad, most things are going poorly
    4) very bad, my life could hardly be worse