Diagnostic Checklist

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Please circle your answers)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
10. Feeling nervous, anxious or on edge	0	1	2	3
11. Not being able to stop or control worrying	0	1	2	3

Over the last 2 weeks, how often have you been bothered by the following problems?

12. Worrying too much about different things	0	1	2	3
13. Trouble relaxing	0	1	2	3
14. Being so restless that it is hard to sit still	0	1	2	3
15. Becoming easily annoyed or irritable	0	1	2	3
16. Feeling afraid as if something awful might happen	0	1	2	3

add columns: _____+ _____+ .

(Healthcare professional: For interpretation of Total please refer to accompanying score card.)

TOTAL: _____

17. If you checked off any of the 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 At All Somewhat Difficult Very Difficult Extremely Difficult

(Please circle your answer)